



Universidade Nova de Lisboa

Escola Nacional de Saúde Pública

# “Obama’s Law – Analysis of a Breakthrough Law on Healthcare Access and Lessons for the Portuguese Health System Management”

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*“The world is accustomed to thinking of the law as an instrument of justice, but not as an instrument of health (...) it is time that the tools of law be harnessed in the service of global health and global justice.”*

Mitchell Blanke et al., 2002

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After a year of hard work my dissertation is finally finished and yet, as the American Novelist, Don Williams, Jr said “our lessons come from the journey, not the destination”. And what a journey it was. How the man I was is no longer the man I am. How can a research have such a profound impact on how I perceived my surroundings and my life?

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## VI Mestrado em Gestão da Saúde

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## Resumo

O *Patient Protection and Affordable Care Act* abalou recentemente as bases do sistema de saúde dos EUA, possibilitando a todos os cidadãos Americanos o acesso aos cuidados de saúde, alterando os mecanismos em que a indústria de seguros de saúde funcionava naquele país. Ao assinar a citada lei a 23 de Março de 2010, o Presidente Obama afirmou que defendia "o princípio fundamental de que todos devem ter alguma segurança básica quando se trata dos seus cuidados de saúde". Ao contrário dos EUA, o artigo 64.º da Constituição da República Portuguesa prevê desde 1976 o direito de acesso universal aos cuidados de saúde. No entanto, enfrentando uma forte crise económica, Portugal tem, sob a vigilância da *Troika*, um calendário apertado para implementar medidas que permitam melhorar a eficiência do Serviço Nacional de Saúde. Ambos os países se encontram, pois, apesar das situações serem diferentes, numa conjuntura de reforma e de utilização de novas medidas de gestão em saúde.

O presente trabalho, utilizando uma metodologia (qualitativa) de pesquisa documental, analisa essencialmente o *Affordable Care Act* de forma a descrever os seus princípios e mecanismos de aplicação. O sistema de saúde português e as medidas a cumprir na área da saúde, ao abrigo do *Memorandum* da *Troika* são também analisadas no sentido de descrever a realidade portuguesa.

O conjunto desta análise tem como finalidade, não só dar a conhecer a inovadora lei norte-americana, mas, sobretudo tentar encontrar algumas medidas inovadoras que pudessem servir a gestão da saúde em Portugal. Identificámos essencialmente as *Exchanges* e os *Wellness Programs*, as quais descrevemos no âmbito do trabalho, deixando a ideia de uma possível utilização das mesmas no sistema de saúde nacional.

**Palavras-chave:** *Affordable Care Act*; *Wellness Programs*; *Exchanges*; *Memorandum*; *Troika*; Gestão Inovadora de Saúde; Acesso aos Cuidados Saúde

## Abstract

The Patient Protection and Affordable Care Act shook the foundations of the US health system, offering all Americans access to health care by changing the way the health insurance industry works. As President Obama signed the Act on 23 March 2010, he said that it stood for “the core principle that everybody should have some basic security when it comes to their health care”. Unlike the U.S., the Article 64 of the Portuguese Constitution provides, since 1976, the right to universal access to health care. However, facing a severe economic crisis, Portugal has, under the supervision of the *Troika*, a tight schedule to implement measures to improve the efficiency of the National Health Service. Both countries are therefore despite their different situation, in a conjuncture of reform and the use of new health management measures.

The present work, using a qualitative research methodology examines the Affordable Care Act in order to describe its principles and enforcement mechanisms. In order to describe the reality in Portugal, the Portuguese health system and the measures imposed by *Troika* are also analyzed.

The intention of this entire analysis is not only to disclose the innovative U.S. law, but to find some innovative measures that could serve health management in Portugal. Essentially we identified the Exchanges and Wellness Programs, described throughout this work, leaving also the idea of the possibility of using them in the Portuguese national health system.

**Key words:** Affordable Care Act; Wellness Programs; Exchanges; *Memorandum*; *Troika*; Innovative Health Management; Healthcare Access.

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## List of Abbreviations

**Ac.:** *Acórdão* (Judicial Decision)

**ACA:** Patient Protection and Affordable Care Act

**ACO:** Accountable Care Organization

**ACSS:** Central Administration for the Health System

**ADSE:** Health subsystem for civil servants

**ARSS:** Regional Health Departments

**Art.:** Article

**BBA:** Balanced Budget Act

**CBO:** Congressional Budget Office

**CHIP:** Children's Health Insurance Program

**CNS:** National Health Council

**CRP:** Constitution of the Portuguese Republic – Constitutional Law

**DGS:** Directorate-General for Health

**DL:** Decree-Law

**DN:** *Despacho Normativo* (Order implementing the Law)

**EC:** European Commission

**ECB:** European Central Bank

**EPE:** Entrepreneurial Public Entities

**ERS:** Health Regulatory Agency

**EU:** European Union

**FFE:** Federally Facilitated Exchange

**FPL:** Federal Poverty Level

**GDP:** Gross Domestic Product

**HHS:** Department of Health and Human Services

**HMO:** Health Maintenance Organization

**IGAS:** General-Inspectorate for Health

**IMF:** International Monetary Fund

**INEM:** National Medical Emergency Institute

**INFARMED:** National Authority of Medicine and Health Products

**INSA:** National Health Institute Dr. Ricardo Jorge

**IOM:** Institute of Medicine

**IPST:** The Portuguese Blood and Transplantation Institute

**IT:** Information Technology

**MMA:** Medicare Prescription Drug, Improvement and Modernization Act

**MoU:** Memorandum of Understanding

**NHS:** National Health Service

**OGE:** General State Budget

**OOP:** Out-of-pocket (Payments)

**OPSS:** Portuguese Observatory of Health Systems

**Port:** *Portaria* (Implementing Order)

**PPPs:** Public-private Partnerships

**PREMAC:** Plan for the Reduction and Improvement of the Central Administration

**SG:** General-Secretariat

**SHOP:** Small Business Health Options Programs

**SICAD:** Service for Intervention in Addictive Behavior and Dependencies

**SPMS:** Central Purchasing Authority

**ULS:** Local Unit of Health

**US:** United States

**USF:** Family Health Unit

**VHI:** Voluntary Health Insurance

**WHO:** World Health Organization

## 1. Introduction

### 1.1 On the theme

The present work is a dissertation project within the VI Master Course in Health Care Management of the National School of Public Health of the New University of Lisbon.

Major changes are happening in the US health system and in the Portuguese health system. One to allow affordable healthcare to its citizens and the other to contain the rise of costs in healthcare. As an added incentive these shifts in healthcare are happening at the same time, which seems important when proposing some orientations. The Patient Protection and Affordable Care Act (ACA) contains methods for organizing and managing the financing of health care that could be useful to Portugal. Furthermore several of the changes proposed by the ACA are planned in the long-term which would allow a gradual assessment of the outcomes. An extra motivation for the elaboration of this work was the possibility of studying the ACA in the US enabling a closer look to this reform.

To understand why the study of this theme seems so propitious the following explanation of what is happening in both countries is important.

As it is well-known a financial crisis has swept the so called “western countries”. Portugal is one of the most affected European countries and so the need to implement new measures of financial nature in a variety of sectors is upon us, the healthcare sector being amongst them. However the healthcare sector is not a typical commercial sector, from a financial perspective, and some financial measures are going to be implemented along with measures of clinical governance.

Consequently in order to implement these measures new Laws need to be enacted and older ones need to be updated. The Law field is once again placed as a cornerstone of the healthcare sector.

As Faria and Lupi (2009) argue, Ethics and Law are simultaneously components of clinical governance and essential instruments for the accomplishment of its objectives. Without ethical principles and fundamental rights a Healthcare System cannot serve the patient, and good clinical governance cannot exist (Faria & Lupi, 2009).

Moreover as, Faria and Lupi (2009) quoted the Australian National Audit Office (2002) the organizations that use clinic governance (almost every health care service) need to ensure that all risks are effectively controlled and managed, and that attention is focused on the core business of the organization – the care and treatment of patients – having an thoroughly

understanding what their responsibilities, both individual and collective are. To do this, both the areas of Ethics and Law are crucial elements since they create bridges of integration between the individual and collective dimension, between the public and the private sector, also, between the health sector and the social sector, regulatory links that are extremely important for a good clinical governance (Faria & Lupi, 2009). To sum up the foregoing Law is essential in the making and maintenance of the health care sector.

Article 64 of the Portuguese Republic Constitution (CRP) states that “*all citizens have the right to health protection and the duty to promote health and defend it*” and this right is obtained through the existence of a universal National Health Service (NHS), approximately free-of-charge (the fees have raised in the last months) and taking into account the citizens’ social and economic conditions (Lei Constitucional nº 1/2005). Moreover the Portuguese Healthcare services have an historical Christian background based in the charity spirit of helping the poor, the sick and the handicapped (Faria, 2010).

Given these facts, the right to health protection is directly linked to the universal access of the healthcare services. The Portuguese NHS is, by all means, based on social justice and solidarity, being financed through direct and indirect taxes, coming from the General State Budget (OGE).

Unfortunately the financial crisis has affected Portugal deeply. Several sectors of the country struggle to maintain a financial equilibrium. A joint effort from a team of three different elements: the European Commission (EC); the European Central Bank (ECB) and the International Monetary Fund (IMF), also known as *troika*, and the XIX Portuguese Government elaborated a programme, where the goals are: “*to restore competitiveness and to put Portugal’s economy back on the path of sustainable growth, sound public finances and job creation*”. One of the documents present in this programme is the *Memorandum of Understanding* (MoU) which details the general economic policy conditions on granting Union financial assistance to Portugal (European Commission, 2011). Concerning the healthcare sector the MoU elaborated a series of measures in order to improve the efficiency and effectiveness of the health care system.

According to the Portuguese Observatory of Health Systems (OPSS), for years specialists have suggested measures to improve the efficiency of the NHS to no avail. In their report of 2011, it is referred that now the fundamental right to healthcare which everyone took for granted since 1976 may be threatened (Observatório Português dos Sistemas de Saúde, 2011).

On the other side of the Atlantic, Barack Obama was elected President of the United States (US) in 2008 and with him the healthcare sector suffered a massive new reform embodied in ACA of March 2010. President Obamas' agenda of implementing a new health reform started to be given a form by the escalating number of state laws to expand access to health insurance, control costs and monitor the quality of care (Mariner, 2007).

In the past, the American health system was based in the corporate welfare, meaning that the majority of American citizens with good jobs had good health plans and citizens with average jobs had average health plans. But as Faria (2004) noticed, by the year 2004, this system led to a situation where approximately 42.3 million American citizens didn't have any health insurance which meant that except the cases of an emergency or lack of income (and the proof of it), all those citizens would have to pay from their own pockets their healthcare services and medicine (Faria, 2004). By the year 2010 the number of uninsured nonelderly American citizens was 49 million, so as we can see after 6 years the problem remains (Holahan & Chen, 2011).

Quoted by Rodwin (2011), in 2009 Himmelstein *et al* mentioned that, illness is a leading cause of personal bankruptcy, even for insured individuals (Rodwin, 2011).

Moreover several healthcare reforms where attempted in the US, but none has achieved what the ACA already did. And there is still more to come.

With the new reform, the ACA, President Barack Obama tries to fight the paper work and social injustice prevalent in the US healthcare system. The ACA intends to allow: a better health security using private and public health insurance companies; a lower cost in health care services; a greater responsibility for the insurance companies; more quality in healthcare; a possibility of choice regarding the insurance companies and a universal coverage.

However it is a well-known fact that the ACA will take years to be fully implemented. Some of the more prominent and complex regulations are still schedule to be written. The rule-making process stretches to 2018, and therefore it stays more susceptible to the intervention of the Congress or to regulatory shifts. In order to prevent this and to boost the popular support for the law, many attractive features of the reform have been implemented ahead of schedule (Kersh, 2011).

Furthermore around the world and affecting all sectors this unprecedented economic crisis is being felt, causing a rise of the health care costs which jeopardizes the implementation of the ACA. A new kind of government intervention is needed in the health sector.

In 2011 Rodwin stated: *“the US lacks the means to effectively control price increases and an oversupply of services”. Even worse, our medical economy is designed to generate expenditures. It rewards insurers, medical facilities, and providers for increasing their price, theirs costs, or the volume of services, without regard to the value to patients or society”* (Rodwin, 2011).

The US health care system is heavily dependent on the private insurance companies. 15 to 20% of premiums are meant to administration and profit, which make the private insurance more expensive than the public insurance (Rodwin, 2011).

In 2004, it was projected that the US health spending would exceed the annual growth in GDP by two percentage points, and that by 2013 the total national health spending would absorb as much as 18.4 percent of the US GDP (Reinhardt, Hussey & Anderson, 2004). We are now in 2012 and the total national health spending is 17.9 percent (Martin et al, 2012).

Especially in a country as the US which became mythical in the defense of its citizens rights and freedoms (Faria, 2004) it is very interesting to study the importance of the ACA and its impact in the years to come, such as to observe if this measures can make the US health care system similar to the one currently existent in Portugal. It is also important to assess to what extent the financial crisis is affecting Portugal, especially in the healthcare sector and how the new measures implemented in the NHS are going to change or not the access to medical care and universal coverage in the country.

With the rising of health expenditure in both Portugal and the US, measures to contain them are needed as it was already mentioned. Besides, financial conflicts of interest have the ability to distort the medical care practice, which is never a good thing, especially for the patients.

In the US with the rise of expenditures in health care, leading insurers and employers shift costs to policy holders, cutting benefits or raising premiums, deductibles, and co-payments, increasing the burden on individuals, and even private insurance with comprehensive benefits often limit the access and fail to provide economic security to its holders (Rodwin, 2011).

After a brief explanation of what it is happening in both health systems it is important to stress the opportunity for improvement the ACA reform may bring to the Portuguese Health system. Since the ACA is happening at the same time as the healthcare measures proposed by the MoU are being implemented it seems appropriate to study each of the reforms and try to understand some methods contained in the ACA that may help or give some orientations on how to organize and improve gaps in the Portuguese Health System. Insurance structures



like the Exchanges and Wellness programs seem to have potential, especially in a health system with universal coverage like the Portuguese one.

It is true that both health systems are distinct, with different backgrounds and with a different history but that does not invalidate that an opportunity for learning and improvement is at hand and that sometimes the best ideas come from the most unexpected places.

## 1.2 Objectives

In order to better understand both health systems and acquire the necessary answers for this research the following objective were established:

- a. To describe the NHS and its main reforms until the present time;
- b. To understand the need for the new healthcare management measures;
- c. To study the ACA and its major impact in the healthcare coverage of the US population;
- d. To describe how the former objective is going to affect the access to health care services and how the insurance companies are going to be involved in the new reform;
- e. To refer the innovative legal instruments of the ACA;
- f. To indicate possible orientations for the Portuguese health system.

In Portugal, the systemic fails in health management cannot be solemnly imputed to the health care sector. We need to comprehend that they are reflected by our degree of progress, our political system culture, and the quality of State institutions, science contribution, technology, learning systems, and finally the behavior of our own society (Observatório Português dos Sistemas de Saúde, 2010).

It is essential that the improvement of the Portuguese NHS sustainability which should always be a priority of the State never puts in risk the principle of the universality in the access to health care (Faria, 2004). This could be a very difficult dilemma to solve.

Also, in 2005, the 58<sup>th</sup> session of the World Health Assembly endorsed a resolution, urging its member countries to work towards sustainable health financing, defining universal health coverage as access for all and to appropriate health services at an affordable cost. Also despite the debatable definition of universal coverage we can generally agree that it comprehends access to key promotive, preventive, curative, and rehabilitative health interventions for all at an affordable cost (Reich, 2011).

In truth different countries have different problems in the Healthcare System but the majority aims to a universal and sustainable health system. Having different backgrounds both Portugal and the US have difficult times ahead but maybe a platform for learning is at hand.

### 1.3 Work Structure

Bearing in mind the principal objective of this work - describing a breakthrough Law in healthcare access and proposing some orientations for the Portuguese health system - the present research is structured in the following chapters:

1. **Introduction** – in this chapter a brief summary of the subject studied is presented, as well as the reasons for conducting the study, its importance and its objectives. It also performs a brief description of the structure of the work.
2. **Methodology** – the second chapter is dedicated to the methodology chosen for this work, in this case the qualitative method. It contains the process of investigation, how the information was gathered and the limitations of the study.
3. **Comparison of Health Expenditure** – this chapter offers a comparison between the health expenditure of both countries. It shows the differences on how Portugal and the US spend their money in health and it gives a better understanding in the need for reforms in both health systems.
4. **Introduction to the Portuguese Health System Legal Framework** – in order to comprehend the need for the new healthcare measures imposed by *troika*, it is crucial to understand how the Portuguese health system came to be and how it is organized. This chapter allows a better understanding of the health system and its changes.
5. **US Health Care Reform** – this chapter presents the ACA, the new healthcare reform of the US. It focuses on the private insurance companies and how they are being used to make health affordable to all citizens. It describes which measures are being applied in order to make universal coverage possible in the US health system. Public programs like Medicaid and Medicare are also covered. The innovative structures contained in the ACA, the wellness programs and the exchanges are described in this chapter. The Massachusetts Health reform law which served as a model for the ACA and may give some insight on what it is to come is briefly analyzed here.
6. **ACA Lessons to the Portuguese Health System Management Framework** – after describing the Portuguese health system and the US health reform, in this chapter is presented a few thoughts about what the ACA and the US health system can bring to the Portuguese health system management framework. Expenditure, especially pharmaceutical expenditure, and resource management are addressed in this

chapter, as well as the innovative tools that could be applied in Portugal, the Exchanges and the Wellness Programs.

7. **Conclusion** – the last chapter brings closure to this work with a few thoughts and opinions regarding the changes that are happening in both health systems.

## 2. Methodology

*“The scientific fact is conquered, constructed and established”* by Gaston Bachelard (cit. Quivy & Campenhoudt, 2008)

The methodology of a science is the reflection of its own activity. It is not only meant to describe the methods used in science but also to understand them, i.e., its needs, its justification and its limits. The need and the justification of a method derive from the meaning, from the structural specificity of the object we plan on studying (Larenz, 1991).

Bearing this in mind, the following chapter will be dedicated to the methodological choice for this research. The present work makes its analysis through the study of documents, texts and laws. This analysis is not compatible with the quantitative method since this method is extensive and it is based on the frequency of appearance of certain content characteristics or the correlation between them (Quivy & Campenhoudt, 2008).

The method of legal science could be a valid choice when studying the right to health care access, especially if a strictly legal approach is made.

Bearing this approach in mind, Cordeiro (1989) stated that considering a broader aspect, the Law is a way of solving concrete cases, which leads to its particular aptitude of adhering to reality. Throughout history it always looked for possible solutions. Furthermore in the XVII and XVIII centuries, the French doctrine tried to find a rational system that corresponded to the need of finding an order for learning and understanding the Law (Cordeiro, 1989).

Cordeiro (1989) also referred that with Savigny and the historical school of Law a purely juridical method was elaborated (Cordeiro, 1989). Furthermore any Law methodology is based on a theory of Law or at least implies it (Larenz, 1991). It should be also clear that the science of law is, first of all, the science of solving concrete cases: the renewal is assumed at the end of the century as a rethinking of dogmatic solutions (Cordeiro, 1989).

However, when taking into account the US Health system legal framework, the provisions implemented by the ACA and the measures proposed and applied to the Portuguese NHS,

this methodology no longer seems suitable to realization of the present research work. Bearing the latter into consideration this methodology was not used.

There is no doubt that the qualitative method is the most suitable one to use in this research, since the former deals with policies and its consequences and tries to form theories regarding possible outcomes and solutions for the problems that are going to affect the Portuguese and the American health system.

According to Graça (2010) the qualitative method is an exploratory and descriptive research. The data are collected in the form of words, pictures and not numbers. The data to be presented and discussed are summarized in the form of quotes, interview transcripts, field notes, photographs, drawings, videos, life stories, narratives, etc...(Graça, 2010).

The research focus is given to the results as well as to the process. Inductive-deductive thinking is where the emphasis is placed when analyzing the data and finally, importance is given to the meaning, to the perspective of the actors in their context. To define the problem, the subject of the study means to answer and explain the questions the researcher has. That is, starting by asking: What? How? Why? Who? How much? How many? (Graça, 2010).

Quivy and Campenhoudt (2008) refer to the qualitative method as extensive and based on the frequency of appearance of certain characteristics of contents or the correlation between them. Furthermore the analysis of this content focuses on messages as diverse as literary works, articles of journals, official documents, audiovisual programs, policy statements, minutes of meetings or reports.

Quivy and Campenhoudt consider this type of method especially suitable for:

- a. Analysis of ideologies, systems of values, representations and aspirations and their transformations;
- b. Examination of the logic of operations of the organizations because of the documents they produce;
- c. The study of artistic and cultural productions;
- d. Analysis of the processes of dissemination and socialization;
- e. Analysis of strategies, of what is at stake, of interpretations, reactions;
- f. The reconstitution of past non-material realities: mentalities, sensibilities.

Since the author had to focus his research in a diversity of articles, literacy works, official documents and policy statements, the qualitative method described by Quivy and Campenhoudt seems to be the logical choice for this investigation.

Also as Shortell (1999) mentioned regarding health services, qualitative research methods can play a major role in developing a science of “evidence-based implementation”. However the rapid pace of change occurring within the health care sector (changes as the new measures for the Portuguese NHS and the ACA in the US) make it increasingly difficult to use existing data sets to address the issues at hand, yet, the ongoing qualitative examination of these rapidly occurring changes offer a fruitful approach for shedding light on emerging forces (Shortell, 1999).

One important point noted on Shortells’ work in 1999 (which is still true in our time) is the fact that complex problems facing health systems throughout the world require multiple methods and approaches for their solution. The complexity of the theme chosen for this work embodies this concept furthermore the qualitative method is particularly appropriate when dealing with the ACA since at present relatively little is known regarding the effects that the reform is going to have in the US health system.

Foremost, the best qualitative research is systematic and rigorous and it seeks to reduce the bias and error, and to identify evidence that disconfirms initial or emergent hypotheses (Sofaer, 1999).

Sofaer (1999) referred that despite the qualitative method being more frequently used in theory development and refinement they can be used in testing theories. This method is also useful in constructing or developing theories or conceptual frameworks or, in other words, the making of hypotheses (Sofaer, 1999).

Indubitably one of the best advantages of the qualitative method is how it enhances the capacity not only to describe events but to understand how and why the “same” events are often interpreted in a different way by different stakeholders. Moreover when dealing with policy research in particular, this method has been used to document perspectives and interactions among multiple stakeholders which are of great value in studies of policymaking, policy implementation, and even of policy consequences (Sofaer, 1999).

The qualitative method has been frequently used for a long time in health services and health policy evaluation mainly because, as Sofaer (1999) states, one of its fundamental strengths is “their ability to explore meanings and, in particular, meanings ascribed to events and circumstances by actors rather than observers” (Sofaer, 1999).

As Sofaer (1999) argues, a researcher cannot afford to ignore the potential contributions of qualitative methods in identifying important questions, in building the capacity to conduct and replicate research, and in constructing useful theories, however, these contributions will not be maximized unless the methods are applied with rigor as well as creativity (Sofaer, 1999).

## 2.1 The Process of Investigation

Kaplan (1969) mentioned that the methodology used in a research does not have the final product of the former one as its main objective but the entire process of its elaboration (cit. Graça, 2010).

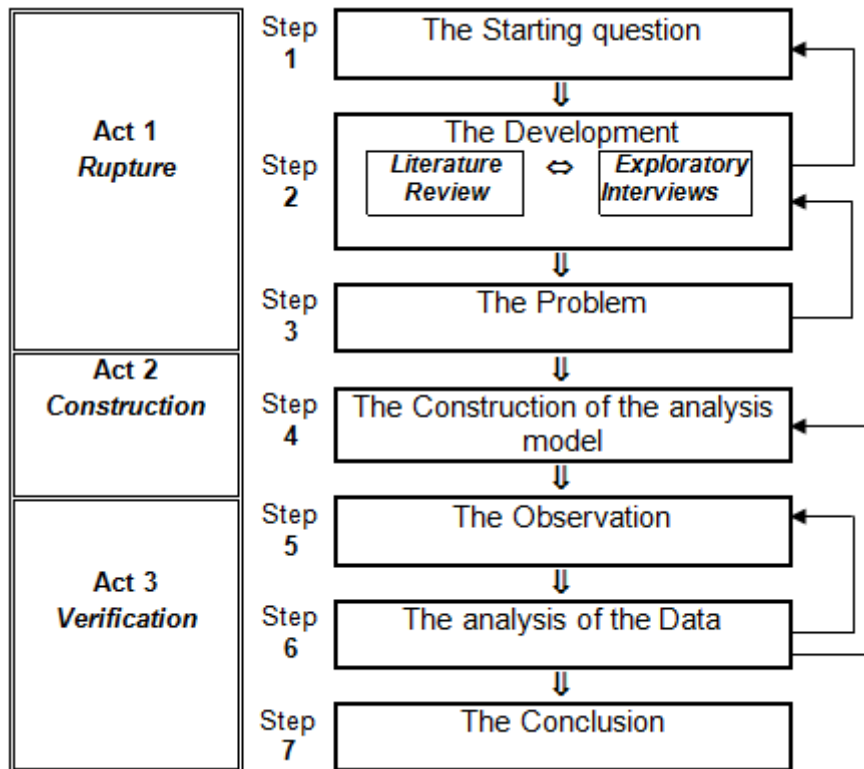
In 1992 Granger argued that the classic definition of method allows us to better understand the strengths and the limitation of our own scientific process, i.e., the production of knowledge (cit. Graça, 2010):

- a. "One method is to follow rules" (...);
- b. "The method searches for the economy of forces" (...);
- c. "The method preserves us from error (never assume what is false as truthful) or, more generally, of missteps" (...);
- d. "The methodical action is exhaustive and cumulative: it allows for a steady growth in science if the goal is knowledge, or obtain partial results if the objective is different".

Nevertheless in order to do a research and although they are not strict, a series of procedures must be adopted by every researcher in any discipline. According to Quivy and Campenhoudt (2008) and referred by Graça (2010) there are seven steps divided by three acts in a process of investigation.

The figure below demonstrates how the acts and steps relate themselves and how the steps connect with each other.

Figure 2.1-1: Process of Investigation



Source: Adapted from Graça, L. - *Guião para o desenho de um projecto de investigação*, 2010.

Concerning the three Acts is important to comprehend what each of them comprises:

1. **Rupture:** it is the first act of scientific procedure and is where the researcher ruptures with the prejudices and false evidence that give us the illusion of understanding;
2. **Construction:** the rupture can only take place if it is performed by an organized conceptual system capable of expressing the logic behind the basis of the phenomenon. It is through this theory that the researcher can raise explanatory propositions of the phenomenon being study and predict which research plan he should use, which operations he should apply and which consequences he should expect at the end of the research;
3. **Verification:** a proposition can only be entitled to the scientific status insofar as it can be verified by the facts.

Furthermore these three acts are not independent, they intertwine themselves. They are carried out through a succession of operations by the seven steps which are in permanent interaction.

Similar to a work elaborated by Marques (2008) this research followed two criteria: it should incorporate legal issues related to health, mainly the health systems and the field of management also related to health.

This fundamental right is intimately related to the access to health care services. It notes that the primary duty of the State to ensure the right to health protection is, as it is written in n.º3 a), *“To guarantee access by every citizen, regardless of his economic situation, to preventive, curative and rehabilitative medical care”* (Lei Constitucional nº 1/2005). Consequently the new measures proposed for the NHS (created by the *Arnaut* Law), are going to impact the access to health care in Portugal especially the ones that implement cost-containment in the Portuguese Health System.

It is in this context that a look to the new American Healthcare reform, the ACA, is taken. As President Obama has voiced the ACA stood for “the core principle that everybody should have some basic security when it comes to their health care”. And although the most visible goal of the ACA is to expand access to health benefit coverage (similar to our universal coverage) to the majority of the uninsured, underlying this goal is an equally important one: the bending of the cost curve or reducing the increase rate of health care expenditures which in the US is almost 18 percent of the GDP (Mariner, 2012b). Nevertheless and contrarily to the Portuguese health measures (which are planned in a short-term), the ACA does not directly regulate the cost of care. Many of its provisions are intended to develop new ways to slow down both the public and the private spending for health care (Mariner, 2012b).

Still, contrary to the Portuguese Health System, the Insurance Companies have long been, since the beginning of the health market, a major player or force in the US health system. And despite the new provisions of the ACA that greatly introduces major changes in the Insurance Companies, the latter are a well establish concept in the US health system.

Converging the changes made to both systems the starting question for this research takes form: Which changes is the ACA going to make to the US health system and can the Portuguese health system learn anything from it?

Of course secondary questions arise: What measures are being implemented in Portugal? How does, the Affordable Care Act, use private Insurance companies to cover everyone? Which legal instruments are truly innovative in the US health reform and what lessons can the Portuguese health system undertake?

It will not be easy to find a consensual answer to these questions and maybe, some of them will remain unanswered. But more important than to find the questions is to find a way to answer them. This is where the methodology comes in. Bearing in mind what was already



written, two types of methods seem to arise as logical choices, the method of Legal Science and the qualitative method.

## 2.2 Particular Features of the Methodology

Having some background regarding the Portuguese NHS and its making and a very small knowledge about the US health system and how their juridical framework works, the qualitative approach was chosen for this research.

The need to ensure a greater identification with the object of the study and to deepen the knowledge and acquire information regarding the two health system left no other choice regarding the method moreover as Polit and Hungler (1993) referred, the qualitative analysis shows concern with the individual and its environment with all their complexities and allows the researcher to be free from any control or limitation concerning other methods. They considered qualitative analysis as holistic and naturalistic (Polit & Hungler, 1993).

As it was already remarked in order to produce a scientific research three essential approaches are needed: a descriptive or analytical approach; an historical or documentary approach and a causal or experimental one (Graça, 2010). However this is not a rigid process, the research does not need to apply all of the approaches during the research. It is possible to use only one, two or all of the approaches during the research.

During this investigation the researcher made particular use of the first two approaches, the descriptive and the documentary. Regarding the new measures for the Portuguese NHS and the new health reform in the US, the ACA, the descriptive approach was very useful and as Fortin (2000) affirmed: *“from the description of the phenomenon and the identification of the several concepts inherent to it, a base could be established for the development of a theory or the formulation of hypotheses”* (Fortin, 2000).

Moreover in order to understand how both health systems came to be, a critical interpretation of past or known facts was needed. The historical or documentary approach assumed that role.

Regarding qualitative studies, there is an inherent danger. Krueger and Casey (2000) argued that these types of studies produce a large amount of data so their analysis must be strict and very well organized. This organization needs to be systemic, sequential, verifiable and continuous (Krueger & Casey, 2000).

As it was mentioned before, the data necessary for the elaboration of this research was obtained primarily through analysis of documents and literature reviews. Nevertheless regarding the US health system and their new reform, the ACA, the study was mainly made at a three months stay in the Department of Health Law, Bioethics and Human Rights of Boston University School of Public Health. The research in this Department was made possible by a Scholar Exchange Program, a collaboration program between the Department of Health Law, Bioethics and Human Rights of Boston University School of Public Law and the National School of Public Health of the New University of Lisbon.

The research on the US health system and the ACA at Boston University was conducted under supervision of Prof. Wendy Mariner. This allowed the researcher to have some guidance regarding the characteristics of this health system, by some of the vanguard of the Public Health sector in the US. Furthermore in order to comprehend the impact of the ACA in the US health system and its influence in the Insurance Companies the researcher attended some classes of Health Reform, Health Insurance and the Law taught by Professor Wendy Mariner.

In addition, the researcher, attended three seminars concerning the ACA, and was allowed to interact with the speakers, posing questions and deepening his knowledge about the American health system and the expected outcome of the ACA reforms.

The period spend at Boston University was very important, I may even say, crucial, since it allowed a better understanding of the US health system and how the ACA is going to affected it. Many of the documents studied were acquired first hand which permitted, almost, a daily update of what was happening in this field. Furthermore with the supervision of Prof. Wendy Mariner, any misconceptions or mistakes regarding the ACA were quickly corrected.

The study of these documents permitted a better understanding of the right of access to health care, both in Portugal and the US, as well as insights into what changes are expected to occur in the near future.

### **2.3 Limitations of the Study**

Graça (2010) mentioned there is always the possibility that there is no appropriate methodology to study a given problem; that the field work may take too long or even that the resources needed are too scarce. Furthermore, qualitative methods sometimes require the use of data or sources that may be confidential or lack scientific credibility (Graça, 2010).

In the present work the first limitation felt by the researcher was his own lack of experience in the elaboration of this type of project. The quantity of references and documents needed for a research of this magnitude can be difficult to manage. Maintaining the focus on the objectives becomes a necessity for a successful research.

To go to the Department of Health Law, Bioethics and Human Rights of Boston University School of Public Health in order to acquire the expertise necessary to comprehend the US health system the researcher needed a visa so that he could enter in the USA. Since 2001, the US has imposed extensive and time-consuming requirements to obtain such a visa, which took up time that would otherwise have been devoted to research.

Perhaps the greatest obstacle or limitation of this research is the fact that both health systems are in flux. During the investigation there were some laws enacted and altered which rendered some earlier research and documents outdated. There was the need to keep the information gathered updated.

### **3. Comparison of Health Expenditure**

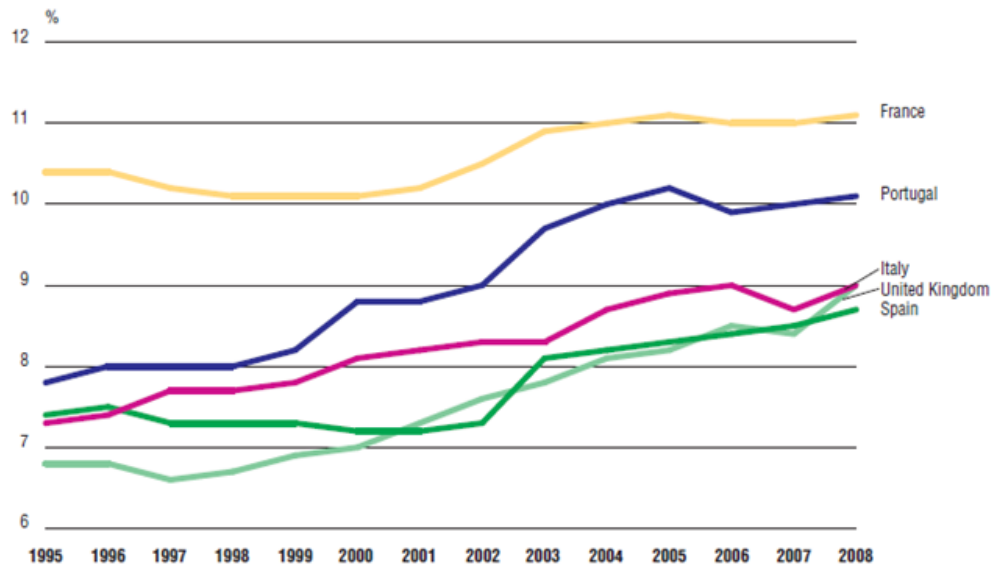
The following chapter is fundamental in order to comprehend what is happening in Portugal, and in a way in the US. The imposed measures of the MoU are directly linked to the health expenditure; moreover, since both health systems are very distinct, a comparison between their expenditure with health may shed some light in what it is to come with the new reforms.

There is no doubt that both in Portugal and the US the total health spending is rising, despite being different health systems with different backgrounds. Even regarding the average of OECD countries both Portugal and the US have unsustainable health expenditures as a share of the GDP.

Between 2000 and 2009 the Portuguese economy faced a period of very low and sometimes even negative growth. The NHS has not adopted any major reform since 1990 despite the growth in healthcare expenditure (Barros, Machado & Simões, 2011), and now Portugal is facing a tight calendar to implement measures in order to improve the efficiency of the NHS, many of them also aiming to control the spending in healthcare.

The Graphic below demonstrates the growth in healthcare expenditure in Portugal as well as the growth from other countries in Europe.

**Figure 3.1-1: Trends in healthcare expenditure as a share (%) of GDP in Portugal and selected countries, 1995-2008**

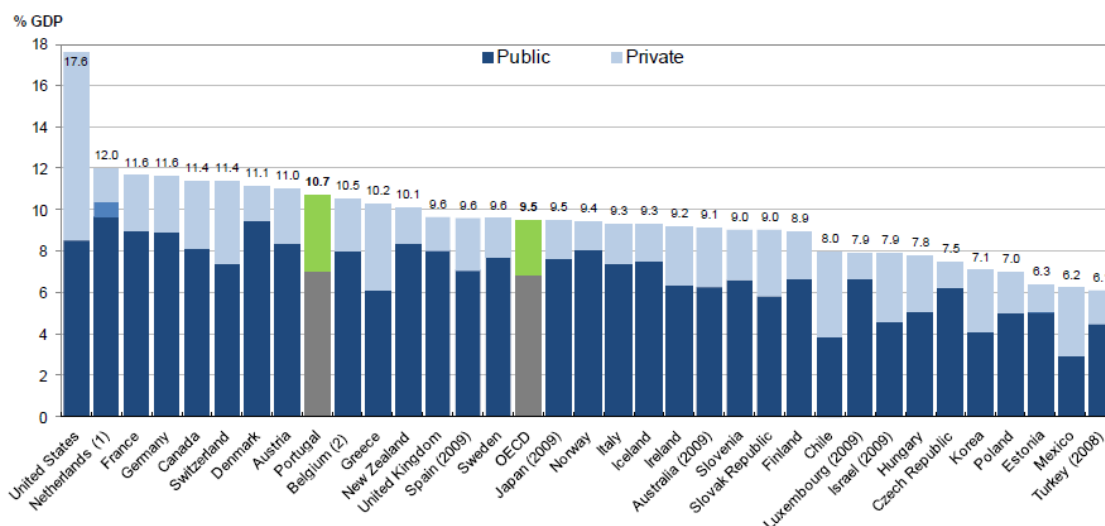


**Source:** WHO Regional Office for Europe, 2011

It is plain to see that Portugal had a rapidly growth in healthcare expenditures as a share of the GDP along the years.

Furthermore, the chart below shows the latest data available regarding healthcare expenditures as a share of GDP, as well as public and private spending, of both countries.

**Figure 3.1-2: Health Expenditure as a Share of GDP, OECD countries, 2010**



**Note:**<sup>1</sup> In the Netherlands, it is not possible to distinguish clearly the public and private share for the part of health expenditure related to investments.

<sup>2</sup> Total expenditure excluding investments.

**Source:** OECD 2012

Both Portugal and the US have a percentage of health expenditure as a share of the GDP above the average of the OECD countries.

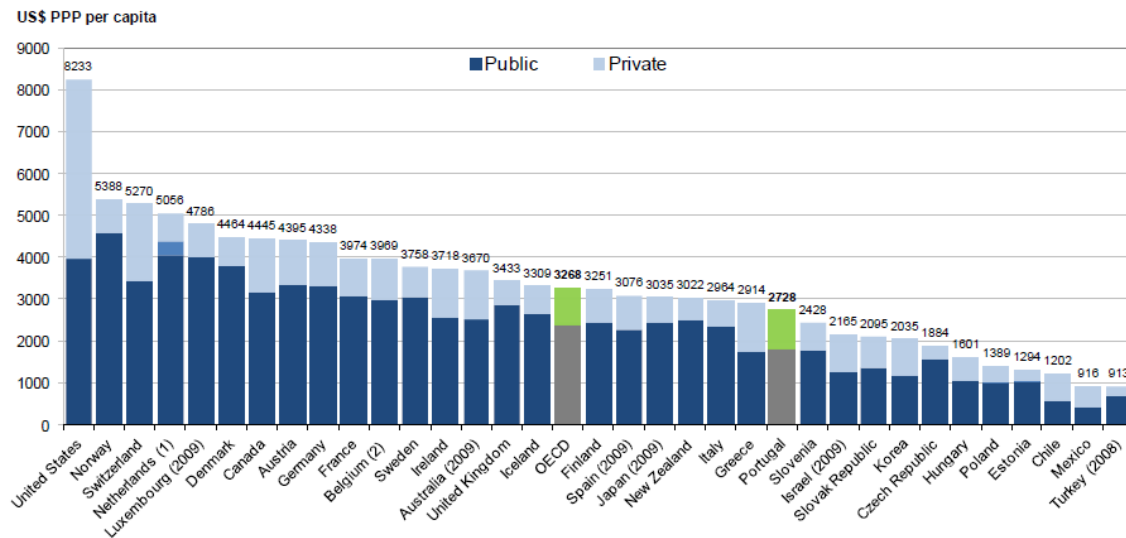
The latest year available in Portugal is 2010, and our total health spending accounted for 10.7 percent of our GDP (OECD, 2012). The US are by far, the country that spends the most on health as a share of its economy, with 17.9 percent of its GDP allocated to health in 2010 (it is a little higher than the share from 2009 which was 17.6 percent) (Martin et al, 2012; Keehan et al, 2011). The total health spending in the US increased in real terms by 4.3 percent per year on average between 2000 and 2009 however this growth rate slowed significantly to 2.7 percent between 2009 and 2010(OECD, 2012).

Taking into account that the average for the OECD countries is 9.5 percent (OECD, 2012), these health expenditures should be targeted for cost-containment measures. Moreover having a share of GDP in health expenditure eight percent points higher than the OECD average (OECD, 2012) and being a country that does not possess a truly universal coverage, the US needs to tread carefully with the new health reform in order not to risk escalating health expenditure.

As Mushlin and Ghomrawi noted, changes in coverage and care delivery must in fact be guided by knowledge about what is valuable to preserve in the health care system (Mushlin & Ghomrawi, 2010). This is both valid in relation to the ACA and its goal of making health care affordable to all American citizens and the new measures proposed for the Portuguese NHS. Changes are being made in both systems. Even though coverage is not an issue in the Portuguese health system, mainly because article 64 of the CRP gives the citizens the right to health protection, alterations in care delivery should not be made blindly. The impact of changes needs to be thoroughly analyzed and predicted.

A further comparison of spending in health care between the two countries leads us to health expenditure per capita. Despite spending a high proportion of its GDP in health, Portugal spent only 2728 US dollars on health per capita in 2010. What is surprising about this is the fact that this value is a lower figure than the OECD average of 3268 US dollars in 2010. In other words Portugal has health expenditure as a share of the GDP higher than the average of the OECD countries and at the same time a lower spending per capita in health than the average of the OECD countries. With its unique health system, the US spent by far the most on health per capita in 2009. The average spending per capita on health in the US was 8233 US dollars (OECD, 2012).

The chart below shows the data in graphic format, including public and private expenditure per capita in the OECD countries in 2010.

**Figure 3.1-3: Health Expenditure per capita, public and private expenditure, OECD countries, 2010**

**Note:**<sup>1</sup> In the Netherlands, it is not possible to distinguish clearly the public and private share for the part of health expenditure related to investments.

<sup>2</sup> Total expenditure excluding investments.

Data are expressed in US dollars adjusted for purchasing power parities (PPPs), which provide a means of comparing spending between countries on a common base. PPPs are the rates of currency conversion that equalize the cost of a given 'basket' of goods and services in different countries.

**Source:** OECD 2012

It is important to note that in the majority of the OECD countries the public sector is the main source of health funding, with the exception of Chile, Mexico and of course, the US. By the year 2010, Portugal had 65.8 percent of health spending being funded by public sources, which is less than the OECD average of 72.2 percent (OECD, 2012). Regarding the data of 2011 there was a slight increase of health spending funded by public sources both in Portugal and the OECD countries (in Portugal the spending was 65.1 percent regarding the year 2008 and the OECD average 71.7 percent). Since in most countries health spending is largely financed out of taxes or social security contributions with private insurance and OOP payments playing a significant but secondary role it is normal for the public sector to be the major funder. The US is one of the few countries where less than 50 percent of health spending is publicly financed, 48.2 percent in 2010 to be precise. On the other hand, the overall level of health spending in the US is so high that public, i.e., the Federal Government, spending on health per capita is still greater than in almost all the countries of the OECD (OECD, 2012).

According to the OECD Health Data (2012) public spending on health in the US has been growing more rapidly than private spending since 1990, largely due to expansions in coverage (OECD, 2012).

## **4. Introduction to the Portuguese Health System Legal Framework**

### **4.1 The Portuguese Health System**

In 1976 the Portuguese Constitution was enacted, being amended for the last time in the year of 2005. In it was Article 64, the most important article regarding healthcare, which stated (Lei Constitucional nº 1/2005):

1. "Everyone shall possess the right to health protection and the duty to defend and promote health.
2. The right to health protection shall be fulfilled:
  - a) By means of a national health service that shall be universal and general and, with particular regard to the economic and social conditions of the citizens who use it, shall tend to be free of charge;
  - b) By creating economic, social, cultural and environmental conditions that particularly guarantee the protection of childhood, youth and old age; by systematically improving living and working conditions and also promoting physical fitness and sport at school and among the people; and by developing both the people's health and hygiene education and healthy living practices.
3. In order to ensure enjoyment of the right to the protection of health, the state shall be under a primary duty:
  - a) To guarantee access by every citizen, regardless of his economic situation, to preventive, curative and rehabilitative medical care;
  - b) To guarantee a rational and efficient nationwide coverage in terms of healthcare units and human resources;
  - c) To work towards the public funding of the costs of medical care and medicines;
  - d) To regulate and inspect corporate and private forms of medicine and articulate them with the national health service, in such a way as to ensure adequate standards of efficiency and quality in both public and private healthcare institutions;
  - e) To regulate and control the production, distribution, marketing, sale and use of chemical, biological and pharmaceutical products and other means of treatment and diagnosis;
  - f) To establish policies for the prevention and treatment of drug abuse.

4. The National Health Service shall possess a decentralized and participatory management system.”

The first two revisions to the Constitution, Constitutional Law 1/81 and Constitutional Law 1/89 added to article 64 the determination that “the management of the NHS should be decentralized and participated” and “considering the economic and social conditions of the citizens it should tend to be free of charge” (Campos, 2001).

Following Article 64 of the 1976 Democratic Constitution which enacted the “right to health protection”, the process of healthcare services restructure met its culmination with the creation of the NHS in 1979 by the *Arnaut* Law, Law 56/1979, of Sep. 15. This law defined the type of healthcare that the NHS would provide, how it should be structured, the personnel status, the funding and the articulation with the private sector (Barros, Machado & Simões, 2011; Campos, 2001).

The *Arnaut* Law established principles of centralized control but with a decentralized management. In order to achieve a decentralized management central, regional and local bodies were established (Barros, Machado e Simões, 2011). Still even after being progressively developed by other statutes between 1979 and 1982, the *Arnaut* Law, according to Campos (2001) was never fully implemented, especially regarding the structure of the central and regional services, the participation and the decentralization of the health system (Campos, 2001).

Despite the creation of the NHS, the legislation field of the Portuguese health system was and still is in a constant change (which is in fact, one of its main traits). Along the years, and as Faria (2010) mentioned, Portugal passed through different health policies phases that strongly influenced the structure of the health system (Faria, 2010).

The first phase, happened after the revolution, from 1976 to 1990, and the prevalent idea was to subordinate the private sector to a social medicine concept in order to make the NHS the only healthcare provider in the country. This concept was expressed in the original version of Article 64, without the two revisions made to the Constitution: Constitutional Law 1/81 and Constitutional Law 1/89, where it was said that the State should “orient its actions to the socialization of medicine” (Faria, 2010).

The creation of the NHS was considered by Article 64 of the Portuguese Constitution as the main element to attain the fulfillment of the “*right to health care protection*” and according to its constitutional disposition, is oriented by principles of universal access, i.e., accessible to all citizens; comprehensive health care services because it offers all kinds of health care needed; pending to gratuity; participated for being managed with the collaboration of all



health care professionals and decentralized, this is, organized through the proximity to the population it serves (Barros, Machado & Simões, 2011; Faria, 2010).

As mentioned in the *Acórdão Constitucional* (Ac. – Judicial Decision) 39/84, of May 5, by creating the NHS, the *Arnaut* Law is considered an instrument to the achieving of the fundamental right to health protection, fulfilling also Article 2 of the CRP which states that (Acórdão n.º 39/84):

*“The Portuguese Republic shall be a democratic state based on the rule of law, the sovereignty of the people, plural democratic expression and organization, respect for the guarantee of the effective implementation of **fundamental** rights and freedoms, and the separation and interdependence of powers, all with a view to achieving economic, social and cultural democracy and deepening participatory democracy.”* (Lei Constitucional nº 1/2005).

In the mentioned *Arnaut* Law the Parliament defined the general basis for the juridical regime of the NHS, entrusting the Government to make the legal developments through its legislative powers by “Decree-Laws” (DL).

It is important to stress here that the right to health protection, such as the majority of social rights, has two distinct components (Acórdão n.º 39/84):

1. A “negative side”, by which citizens have the prerogative to demand that no one, not even the State, acts or makes any measure that violates the fundamental right (in this case the right to health protection);
2. A “positive side”, that consists in bestowing the citizen the right to demand from the State the installments and activities necessary to the healthcare protection.

Hence, the creation of the NHS by the *Arnaut* Law is an essential milestone in the legislative context regarding the right to health protection.

To sum up the foregoing, in 1979 the Portuguese health system had the following characteristics:

1. Legislation that would establish the right to health protection to all citizens;
2. A guaranteed right to universal coverage and free healthcare under the NHS;
3. Access through the NHS to all citizens independently of their economic or social background;
4. Integrated healthcare, including health promotion, disease surveillance and prevention;
5. A tax financed system of coverage in the form of the NHS.

Still within the first phase, in 1986, Portugal became a member of the former European Economic Community now known as European Union (EU), therefore becoming eligible for European funding for social and economic infrastructures development which include the healthcare sector. With this funding the NHS facilities were able to expand in a better and more sustained way (Faria, 2010).

After the Article 64 of the CRP and the *Arnaut* Law, the second phase in the legislation field went from 1990 to 2002 and was initiated with a big reform in the Portuguese health system, the approval of the Health Bases Law (LBS), Law 48/90 of August 24<sup>th</sup> (Faria, 2010). This law altered the whole philosophy of the health system, the citizens were now considered primarily responsible for their own health, having the duty to promote and defend it (Campos, 2001).

The LBS served as a milestone in the shaping of the entire health sector in Portugal. It embodied the rights and duties of the citizens as users of the system, the organization of the main structure of the healthcare system; the main powers of the public entities in the health system; the responsibility of the State, etc. This Law was a major step in defining our present Health System not only as state responsibility but in involving the citizens and the private entities of the health sector.

Base I of the LBS has four general principles that demonstrate the responsibility of the State, the community and the citizens in the health protection, the delimitation of the health care provided by the State in light of the resources and financial capability, and finally, the definition of the range of action of private medicine in health care (Lei n.º 48/90):

1. "The Health protection right constitutes a right of the individuals and the community that is accomplishable by a conjoint responsibility from the State, society and citizens, with the freedom to search for health care as it is written in the law and Constitution;
2. The State promotes and assures health care access to all citizens according to the technical, financial and human resources available;
3. The defense and promotion of public health is assured through the action of the State and other public entities. Civil society organizations are also able of being associated to this action;
4. Health care is provided by services and institutes of the State or, under its control, by public or private entities (social or profit aimed)."

As noticed by Faria (2010) the enactment of this law gives, for the very first time, an entrepreneurial orientation legal framework to the health sector and with it the creation of two crucial points (Faria, 2010):

i. The integration of the NHS in a real Health System context;

As mentioned above, the creation of the NHS was meant to subordinate the private sector to a social medicine concept, which led to a disregard of the existence of a very important private and social sector in the health framework. The LBS created for the first time in Law terms the concept of Health System. According to the Base XII of the law, besides Ministry of Health dependent public hospitals and health centers, i.e., the NHS, the private health care institutions that had contracts with the NHS were inserted in it (Faria, 2010; Lei nº 48/90).

ii. The birth of private management in the public health sector;

This new law aimed to stimulate the Portuguese private health sector and mainly the private management of the NHS facilities (Faria, 2010). Besides the principle of entrepreneurial management of the health care units, innovating experiences of administration of services through management contracts were encouraged (Campos, 2001). The starting point for this was the hospital *Fernando da Fonseca*; a new 600 bed public hospital near Lisbon built by the State and opened in 1995, and with *Portaria* (Port) 27/95 under the management contract with a private consortium (*Portaria* n.º 27/1995).

Furthermore, in 1993, the DL 11/93 of January 15<sup>th</sup> was approved which establish the separation between service and system. The NHS is a fundamental piece of the health system but it is not his exclusive piece in order to ensure the right to health protection. The health system is constituted by public agents but also by private agents (Campos, 2001). Article 28, n.º 1 e 2 of this DL also allowed the Ministry of Health through management contracts to authorize the delivery of management of Health care services and institutions of the NHS to public or private entities. However this was revoked by DL 185/2002 of August 20<sup>th</sup> (Decreto-Lei n.º 11/93; Decreto-Lei n.º 185/2002).

The third phase begins in the year 2002 with the first and only amendment to the Health Bases Law; Law 27/2002, of November 8<sup>th</sup>, and is still going on. This law permitted the transformation of 34 public hospitals in 31 SA companies (*Sociedades Anónimas* – Joint Stock Companies) switching these institutions from the state administrative sector, with public statute and management, to the state entrepreneurial sector, private statute and management. Law 27/2002 of November 8<sup>th</sup> added a number 3 to Base XXXVI of the LBS stating (Faria, 2010; Faria & Campos, 2003; Simões, 2004; Lei n.º 27/2002):

*“The law can predict the creation of health units with corporative nature and public capital”*  
(Authors Translation)

By January, 2003, approximately 30% of the Portuguese public hospitals, which corresponded to roughly 50% of the public sector bed capacity, were managed under a private legal framework. However, 2005 brought a new switch in the legal nature of hospitals. The DL 233/2005 of December 29<sup>th</sup> transformed the 31 SA hospitals into 31 “EPEs” hospitals, i.e., Entrepreneurial Public Entities. The management of these hospitals was once again integrated in the public sector rules. The main reason for this change was the possibility of extinction of the SA hospitals by bankruptcy, according to Companies Commercial Code (Código das Sociedades Comerciais) (Faria, 2010; Rego & Nunes, 2009). Still one of the major changes to the transformation of the SA hospitals into EPE hospitals is the State Responsibility, i.e., change in the legal regime with the increase of the State amplitude as an instrument of economic intervention. The tutelage is exercised by the Ministers of Finance and Health just like in the SA hospitals (Observatório Português dos Sistemas de Saúde, 2005). Hospital *Fernando Fonseca* became an EPE by the year 2008 with DL 203/2008 of October 10<sup>th</sup>, leaving the private management and returning to State control (Decreto-Lei n.º 203/2008).

Despite the health policy divergences that punctuated this period it has also been marked by the solidification of the entrepreneurial management scheme in public health units. As Faria (2010) referred this assertion may be seen in hospitals by the Public-Private Partnership (PPPs) initiative and the creation of the Family Health Units (USFs) in health centers (Faria, 2010).

i. The PPPs

Under the PPPs framework, private investment, public financing and private management, ten new public funded and owned hospitals were expected to be constructed in the next few years. The PPPs are defined by DL 86/2003 of April 26<sup>th</sup>, art. 2/1 as a Union of Contracts under which private entities, also known as private partners, oblige themselves before a public partner, to a lasting performance of a collective need. The financing, investment and management of the contract celebrated with the public partner belong altogether or partly to the private entity. The provision of health care by the private partner is the object of the PPPs in the health care sector. Typically these partnerships consist of one or more of the following activities: conception, construction, financing, conservation and management of the health units (Decreto-Lei n.º 86/2003; Faria, 2010; Simões, 2004). According to Simões (2004), in the healthcare sector normally the PPPs have the following triple of vectors: public planning and financing; private investment and management; public control and ownership (Simões, 2004).

However, lately, this initiative has been questioned since the costs of the PPPs have been too high to the public sector.

ii. The USFs

When they appeared, the Family Health Units represented the main innovation of the management of primary health care units making use a variety of market mechanism within the public sector. The USF possess a strong and close relationship with the local Health Centers and as primary health care units they mainly use contract based management tools to set a basic series of health services that should be accessible to all population (Faria, 2010).

It is important to stress that despite the LBS setting primary health care as a priority the Portuguese Healthcare System has been too Hospital centered. The USFs appeared as a breakthrough in the primary care public sector strategies and an embodiment of the new implemented policies that aim to reduce Hospital over-utilization, rationing the use of resources and create incentives for citizens to have a family doctor, offering a range of basic health care services in close proximity to the population. Their management model introduced a new dynamic in the health care system because it reinforced the shared responsibility between health care professionals to comply with the performance agreements. In the past, health centers were mainly focused in the physician's responsibility and the management was not based on the performance levels (Faria, 2010).

With the MoU the number of USFs contracting with regional authorities is going to increase in order to have a more effective provision of primary health care and a reduction of its costs (European Commission, 2011).

So as it is noticed by Barros and Simões (2007), between 2002 and 2005 the NHS due to its interaction between the public sector and the private sector, and its integration of the primary, secondary and long-term care became a mixed system (Barros & Simões, 2007).

From 2005 to 2009 the Portuguese Health Policy aimed to combine the universal coverage provided by the NHS and the promotion of effectiveness and efficiency (Barros, Machado & Simões, 2011). Furthermore one of the priorities for the health system in the National Health Plan of 2004-2010 was providing the citizen a timely quality service (improvement of access), with effectiveness, humanity and with sustainable costs over time (Ministério da Saúde, 2004).

Overall, at the end of the first decade of the 21<sup>st</sup> century the major challenges faced by Portugal were (Barros, Machado & Simões, 2011):

- a. The rising of health expenditures and difficulties in cost-containment;
- b. The continuous impact of technology and innovation in medical practice on the growth of expenditures;
- c. The increasing role of IT in health promotion and health care delivery in order to make them effective tools in bringing health care services in remote locations closer to the population;
- d. An ageing population associated to a pressure in continuous and long-term care;
- e. Difficulty in reducing mortality due to life style related diseases and traffic accidents.

With the need to face all these challenges and with the financial crisis affecting Portugal we may be on the break of a new phase. A phase initiated with *troikas*' imposed measures for the healthcare sector.

In 2011, April 7<sup>th</sup> Portugal requested financial assistance which was endorsed by the European Commission on 10 of May 2011. This endorsement was negotiated between the Portuguese authorities and officials with *troika* and resulted in a programme of economic adjustment for the period between 2011 and 2014. Portugal will receive up to EUR 78 billion in loans and in return will implement measures to promote growth and jobs, fiscal measures to reduce the public debt and deficit, and measures that will ensure the financial sector stability (European Commission, 2011).

As document of the economic adjustment programme, MoU, also had measures for the healthcare sector. The goal of these measures is to improve efficiency and effectiveness of the health care system.

Furthermore and as it is written in the *Despacho Normativo* (DN) 10783 – A/2011 of August 31<sup>th</sup>, the MoU signed by the Portuguese Government with the IMF, EC, and the ECB predicts a more strict control on the debt level of the State business sector to which belongs the health Entrepreneurial Public Entities (EPE), *i.e.* the majority of Portuguese hospitals. Many of the most important measures focus in the hospital services area (Despacho n.º 10783-A/2011).

Moreover the guideline for the accomplishment of the 2012 Performance Plan establishes that: *“the predictions for the economic budget should take into account the necessity of assuring the cost control of the Institution, mainly the costs with personnel, external services and goods, suppliers, pharmaceutical and clinic consumption, considering mandatory the reduction of operational costs by, at least, 5% when in comparison with 2011”* (Despacho n.º 10783-A/2011).

Besides what is stated in the 2012 Performance Plan, the DN 10783 – A/2011 emitted by the Ministries of Finance and Health, signed 30 of August 2011 (*Diário da República*, 31 of August 2011) refers as aim for the year 2012 the reduction of the operational cost of Hospitals, Hospital centers and local units of health (ULS), all of them integrated in the State Entrepreneurial sector. The goal is a fixed value of 11% inferior to that of the year of 2011 (Despacho n.º 10783-A/2011).

For the aforementioned reasons, the constant changes of government and the need to comply with *Troika* measures (which will be addressed further on) it seems that the reforms in health tend to bet more on an entrepreneurial management of Hospitals where there is an evident reduction of direct State involvement in planning, managing and providing health care.

## 4.2 An Overlapping System

After comprehending the legal framework that embodied the creation of the Portuguese Health System an overview of the organizational aspect of the system is important to understand how new policies and measures are implemented.

According to Barros, Machado and Simões (2011) the current Portuguese Healthcare System is characterized by three coexisting and overlapping systems:

- a. The (universal) NHS;
- b. The “healthcare subsystems”, *i.e.* public and private insurance schemes pertaining to certain professions (e.g. civil servants; bankers; judges);
- c. And private voluntary health insurance (VHI).

Taking into account the LBS of 1990, the NHS already covers every Portuguese citizen, however the healthcare subsystems and the VHI have gradually position themselves as complementary insurance regarding the NHS. The cases of people with double coverage have been multiplying. Currently, approximately 25 percent of the population has a healthcare subsystem and 10 to 20 percent have a VHI (some citizens have both). In 2008 the number of citizens with a VHI was two million (Ministério da Saúde. CSFSNS, 2007; Barros, Machado & Simões, 2011; Deloitte, 2011).

The healthcare subsystems have been suffering a great deal of pressure from costs, even more than the NHS, as well as the pressure related with the rising number of beneficiaries that depend from their services. Even so, despite the use of healthcare subsystems and VHI, the tendency of citizens with a worse state of health to use the NHS is increasing, which

leads to the higher costs with health being supported by the public system (Barros, Machado & Simões, 2011; Deloitte, 2011). Furthermore the healthcare subsystems functions just like a regular health system with a considerable number of citizens benefiting from protection mechanisms when in need of medical attention (in addition to the protection provided by the NHS). According to Campos (2007) the healthcare subsystems introduce an inequitable factor in the Portuguese Health System. Citizens with double coverage have privilege access to healthcare services and differential public financing from various sources (for example transfers for the ADSE through the Ministry of Finance) which should not exist in a universal and general NHS (Ministério da Saúde. CSFSNS, 2007).

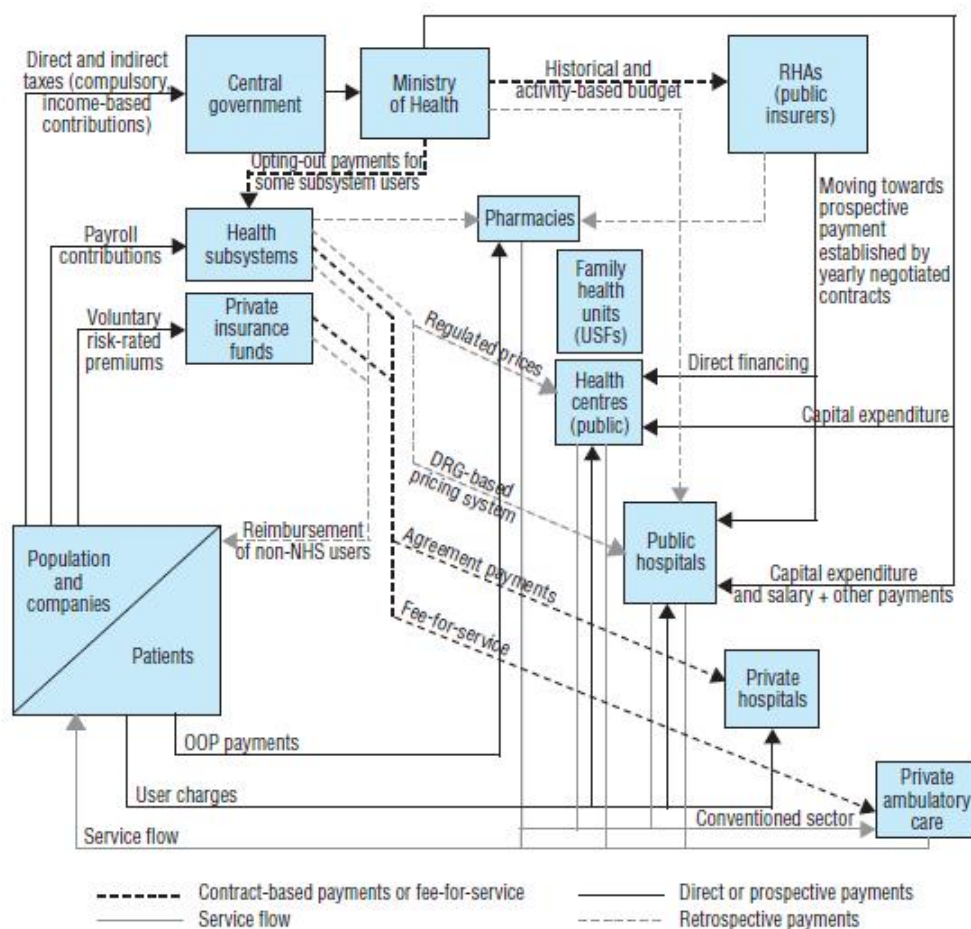
Regarding the VHI market in Portugal, it is a fairly recent as it came to existence in the early nineties offering a limited amount of products in terms of coverage and benefits offered. The insurance sector defines itself as complementary and supplementary to the Portuguese NHS (Ministério da Saúde. CSFSNS, 2007). This market is also growing in Portugal, according to Barros, Machado and Simões (2011) in the year 2008 the growth of the health insurance sector was 9.6 percent which was higher than the 8.2 percent growth rate of the year 2007. The justification for this growth was the increase in group insurance (Barros, Machado & Simões, 2011).

It was already referred that Health care in Portugal is mainly financed by public funds. This assumes a bigger role when taking into account healthcare subsystems and VHI because their activity is relevant for the financing of the Portuguese Health System creating stimuli to the provision of public and private healthcare services (Faria, 2010; Ministério da Saúde. CSFSNS, 2007).

The Portuguese health system is a complex one; the three systems that characterize it coexist and intertwine themselves. The chart below demonstrates how complex the system is.



Figure 4.2-1 - Overview chart of the Portuguese Health System



SOURCE: From Simões, J.A. - Portugal : Health system review, 2011 pp. 16

Barros, Machado and Simões (2011) argued that the healthcare delivery system in Portugal consists in a network of public and private health care providers connected in its own way to the Ministry of Health and to the patients. In addition they can have different agreements regarding the financial aspect, ranging from historically based budgets to purely prospective payments. Barros, Machado and Simões (2011) also mentioned that the Out-of-pocket (OOP) payments assume a significant portion of the financial flows of the system (Barros, Machado & Simões, 2011).

Also the Portuguese State has a multiple role in the governance of healthcare. It assumes the role of supervisor, regulator, payer and shareholder making it hard to ensure an optimum performance in all of the functions and creating conflicts of interest and a lack of transparency (Deloitte, 2011).

As Faria (2010) and Barros, Machado and Simões (2011) remarked the vertex of the administrative pyramid of the Portuguese Health System is the Ministry of Health who acts as

the central government and is responsible for the development of health policies and the evaluation of their implementation (Faria, 2010; Barros, Machado & Simões, 2011).

Moreover the core function of this Ministry is to define health policies and act as the regulator, the planner and the manager of the NHS. It also regulates audits and inspects private health services providers even if they are not integrated in the NHS (Barros, Machado & Simões, 2011).

To sum up the foregoing the Portuguese Ministry of Health comprises a very complex and heavy system that relies on the interaction of different juridical kinds of entities, particularly central services and departments, public agencies, enterprises and consulting bodies and healthcare units, with diverse functions, from management to healthcare delivery. In all these entities the Ministry of Health exercises different types of powers (Faria, 2010).

In the last few years the Ministry of Health has been the object of important administrative reforms by new statutes. The last one occurred with the DL 124/2011 29<sup>th</sup> of December and approved the Ministry of Health Organic Statute which came in line with the Plan for the Reduction and Improvement of the Central Administration (PREMAC). The Ministry of Health is made of several institutions. Four central bodies under direct administration from the State with special and diverse powers including regulation and evaluation ones, other bodies integrated under indirect State administration, advisory bodies and other structures and entities incorporated in the State entrepreneurial sector. It should be noted that the Health Regulatory Agency (ERS) is formally independent in its actions and decisions even though their budget comes mostly from the Ministry of Health (Decreto-Lei n.º124/2011; Barros, Machado & Simões, 2011; Faria, 2010).

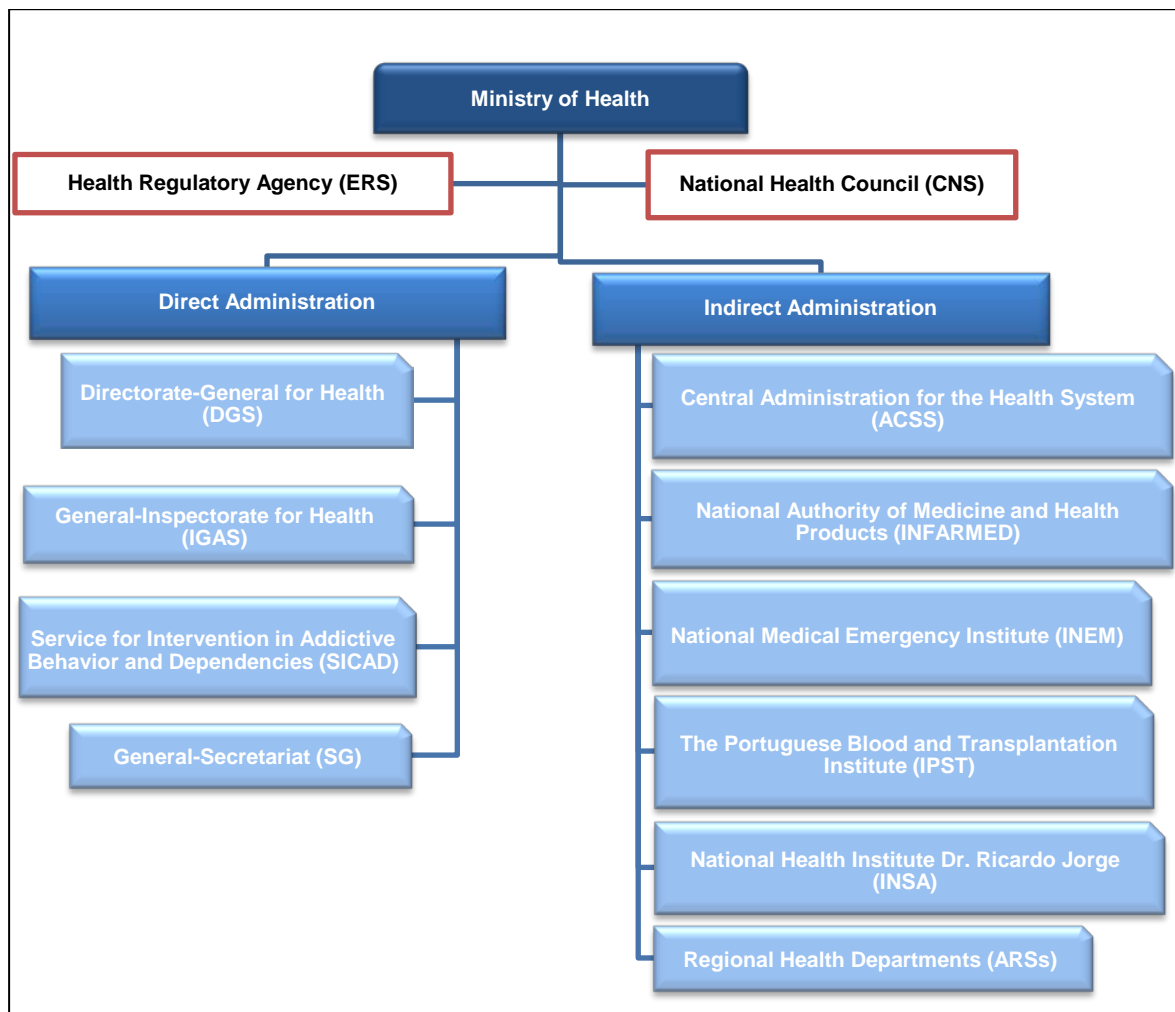
The four central bodies immediately underneath the Ministry of Health and under direct government administration and according to the Ministry of Health Organic Statute are:

- a. General-Secretariat (SG) (Art. 10, *ibid*);
- b. General-Inspectorate for Health (IGAS) (Art. 11, *ibid*);
- c. Directorate-General for Health (DGS) (Art. 12, *ibid*);
- d. Service for Intervention in Addictive Behavior and Dependencies (SICAD) (Art. 13, *ibid*).

There are several central services, working under the supervision of the Ministry of Health and belonging to the indirect government administration, which also execute the objectives of the Ministry. These entities according to Art. 5/1 and 2 of the Ministry of Health Organic Statute are the following:

- a. Central Administration for the Health System (ACSS) (Art. 14, *ibid*);
- b. National Authority of Medicine and Health Products (INFARMED) (Art. 15, *ibid*);
- c. National Medical Emergency Institute (INEM) (Art. 16, *ibid*);
- d. The Portuguese Blood and Transplantation Institute (IPST) (Art. 17, *ibid*);
- e. National Health Institute Dr. Ricardo Jorge (INSA) (Art. 18, *ibid*);
- f. Regional Health Departments (ARSs) (Art. 19, *ibid*).

**Figure 4.2-2: Main Organizational Chart of the Ministry of Health**



Note: The National Health Council acts as a consultative body to the Ministry of Health

SOURCE: Adapted from Decreto-Lei n.º 124/2011

### 4.3 *Troika* imposed Healthcare Sector Measures

For the past few years the Portuguese health expenditure as a percentage of the National Gross Domestic Product (GDP) has been steadily growing. In the period of 2000-2009, it has

grown at an average annual rate of 2.3%, exceeding in this manner, the growing of the GDP (Despite slowing down to 0.6% in 2010). (OECD, 2012)

At this rate our health care system is expected to become unsustainable, and so strict measures have been put in action.

The Program of the XIX Government (into power since 5 of June 2011) recognizes that “the time to act has come”.

Measures proposed by the MoU were made with an agreement between the XIX Government and *Troika*. *Troika* is going to evaluate the state of Portugal finances and define were to apply the funds given.

According to the MoU the objectives for the health care system are (European Commission, 2011):

1. Improve efficiency and effectiveness in the health care system;
2. Inducing a more rational use of services and control of expenditures;
3. Generate additional savings in the area of pharmaceuticals to reduce public spending on pharmaceutical to 1.25 percent of the GDP by the end 2012 and to about 1 percent of GDP in 2013 (in line with EU average);
4. Generate additional savings in hospital operating costs and devise a strategy to eliminate arrears.

In line with the objectives of the MoU, the XIX Government has as its prime objective for the health system: assure, in medium-term, the financial sustainability of the NHS ensuring at the same time the quality and the access of the citizens to health services (Ministério das Finanças, 2012).

As Kenneally and Walshe (2012) noted and is defined by the World Health Organization (WHO), health system sustainability is the “ability to meet the needs of the present without compromising the ability to meet future needs”. Moreover these authors consider that a health system is fiscally sustainable if the government is able and willing to meet its health system obligations (Kenneally & Walshe, 2012).

Bearing these premises in mind is easier to understand why the measures of budgetary adjustment of the XIX Government are guided by two fundamental assumptions (Ministério das Finanças, 2012):

1. An equitable distribution of effort by the several stakeholders of the sector (mainly the entities of the Ministry of Health, health professionals, suppliers, patients, among others);
2. Measures with a sustainable budgetary impact in the medium and long-term.

In fact, according to the budgetary strategy (2011-2015) the already initiated fiscal consolidation will promote a rationalization of the available resources, the restraint of the waste and expenditure, fraud control, maximize returns on the available resources and a rationalization of the facilities and health infrastructures in order to do the same with less resources while ensuring the quality and access of the citizens to the health care (Ministério das Finanças, 2012).

However as Mushlin and Ghomrawi (2010) commented in order to devise ways to improve and maximize health with limited resources, keener insights are needed. If the emphasis of the measures is on cost reduction, there is an added incentive to do research and development that will bring to the marketplace, not only superior therapeutics, but also equivalent interventions that are cheaper than their predecessors and therefore more cost-effective. (Mushlin & Ghomrawi, 2010).

Foremost, the objectives referred in the MoU are portrayed by several measures combined in different areas. Quoting by area some of the more important ones on the MoU (European Commission, 2011) we have:

“Financing

- a. **3.51.** Review and increase overall NHS moderating fees (taxas moderadoras) through:
  - i. a substantial revision of existing exemption categories, including stricter means-testing in cooperation with Minister of Social Security;
  - ii. increase of moderating fees in certain services while ensuring that primary care moderating fees are lower than those for outpatient specialist care visits and lower than emergency visits;
  - iii. legislate automatic indexation to inflation of NHS moderating fees.
- b. **3.53.** In the light of the urgency and size of the savings needed in the health sector to address large arrears and budget limitations plans to achieve a self sustainable model for health benefits schemes for civil servants will be accelerated. The current plan foresee that the overall budgetary cost of existing schemes – ADSE, ADM (Armed Forces) and SAD (Police Services) - will be reduced by 30% in 2012 and by further 20% in 2013 at all levels of general government. The system would become

self-financed by 2016. The budgetary costs of these schemes will be reduced by lowering the employer's contribution and adjusting the scope of health benefits.

#### Pricing and reimbursement of pharmaceuticals

- c. **3.56.** Move the responsibility of pricing medicines to the Ministry of Health (for example to the Infarmed).
- d. **3.57.** Revise the existing reference-pricing system based on international prices by changing the countries of reference to the three EU countries with the lowest price levels or countries with comparable GDP per capita levels.

#### Prescription and monitoring of prescription

- e. **3.58.** Make electronic prescription for medicines and diagnostic covered by public reimbursement fully compulsory for physicians in both the public and private sector.
- f. **3.60.** Induce physicians at all levels of the system, both public and private, to prescribe generic medicines and the less costly available branded product.
- g. **3.62.** Remove all effective entry barriers for generic medicines, in particular by reducing administrative/legal hurdles in order to speed up the use and reimbursement of generics.

#### Pharmacies sector

- h. **3.64.** Change the calculation of profit margin into a regressive mark-up and a flat fee for wholesale companies and pharmacies on the basis of the experience in other Member States. The new system should ensure a reduction in public spending on pharmaceuticals and encourage the sales of less expensive pharmaceuticals. The aim is that lower profits will contribute at least EUR 50 million to the reduction in public expense with drugs distribution.

#### Centralised purchasing and procurement

- i. **3.66.** Set up the legislative and administrative framework for a centralised procurement system for the purchase of medical goods in the NHS (equipments, appliances, pharmaceuticals), through the recently created Central Purchasing Authority (SPMS), in order to reduce costs through price-volume agreements and fight waste.
- j. **3.68.** Take measures to increase competition among private providers and reduce by at least 10 per cent the overall spending (including fees) of the NHS with private providers delivering diagnostic and therapeutic services to the NHS by end 2011 and by an additional 10% by end 2012.

- k. **3.70.** Introduce a regular revision (at least every two years) of the fees paid to private providers with the aim of reducing the cost of more mature diagnostic and therapeutical services.
- l. **3.71.** Assess compliance with European competition rules of the provision of services in the private healthcare sector and guarantee increasing competition among private providers.

#### Primary care services

- m. **3.72.** The Government proceeds with the reinforcement of primary care services so as to further reduce unnecessary visits to specialists and emergencies and to improve care coordination through:
  - i. increasing the number of USF (Unidades de Saúde Familiares) units contracting with regional authorities (ARSs) using a mix of salary and performance-related payments as currently the case. Make sure that the new system leads to reduction in costs and more effective provision;
  - ii. set-up a mechanism to guarantee the presence of family doctors in needed areas to induce a more even distribution of family doctors across the country.

#### Hospital services

- n. **3.73.** Set out a strategy and a binding timetable to clear all arrears in the health sector. The strategy will include the introduction of standardised and tight control procedures for all health sector entities to prevent the re-emergence of arrears. In addition, a mechanism is put in place to ensure strong coordination between the Ministry of Health and the Ministry of Finance for the application of the same monitoring and control criteria to all types of hospitals.
- o. **3.75.** Provide detailed description of measures aimed at achieving a reduction of at least EUR 200 million in the operational costs of hospitals in 2012 (EUR 100 million in 2012 in addition to savings of over EUR 100 million already in 2011). This is to be achieved through the reduction in the number of management staff, concentration and rationalisation in state hospitals and health centres and annual ceilings to PPP contracts.
- p. **3.78.** Set up a system for comparing hospital performance (benchmarking) on the basis of a comprehensive set of indicators and produce regular annual reports, the first one to be published by end 2012. Indicators are to include financial indicators.
- q. **3.79.** Ensure full interoperability of IT systems in hospital, in order for the ACSS to gather real time information on hospital activities and to produce monthly reports to the Ministry of Health and the Ministry of Finance.

- r. **3.80.** Continue with the reorganisation and rationalisation of the hospital network through specialisation and concentration of hospital and emergency services and joint management (building on the Decree-Law 30/2011) joint operation of hospitals. These improvements will deliver additional cuts in operating costs by at least 5 per cent in 2013. A detailed action plan is published by 30 November 2012 and its implementation is finalised by the first quarter 2013. Overall, from 2011 to 2013, hospital operational costs must be reduced by at least 15% compared to 2010 level.
- s. **3.81.** Move some hospital outpatient services to primary care units (USF).
- t. **3.84.** Introduce rules to increase mobility of healthcare staff (including doctors) within and across health regions. Adopt for all staff (including doctors) flexible time arrangements, with a view of reducing by at least 20% spending on overtime compensation in 2012 and another 20% in 2013. Implement a strict control of working hours and activities of staff in the hospital.

#### Regional health authorities

- u. **3.85.** Improve monitoring, internal control and fiscal risks management systems of the Administrações Regionais de Saúde by Q4-2012.

#### Cross services

- v. **3.86.** Finalise the set-up of a system of patient electronic medical records.
- w. **3.87.** Reduce costs for patient transportation by one third."

The table below demonstrates when each of the chosen measures should be implemented as well as its area of operation.

**Table 4.3-1: Measures of the Memorandum of Understanding**

Area of Operation	Measure	Date of Implementation
<b>Financing</b>	3.51.	
	i.	September - 2011
	ii.	September - 2011
	iii.	Quarter 4 - 2011
	3.53.	Quarter 4 - 2011
<b>Pricing and Reimbursement of Pharmaceuticals</b>	3.56.	Quarter 4 - 2011
	3.57.	Quarter 4 - 2011
<b>Prescription and Monitoring of Prescription</b>	3.58.	Quarter 3 - 2011
	3.60.	Quarter 3 - 2011
	3.62.	Quarter 4 - 2011



<b>Pharmacies Sector</b>	3.64.	Quarter 4 - 2011
<b>Centralized Purchasing and Procurement</b>	3.66.	Quarter 3 - 2011
	3.68.	Quarter 4 - 2011
	3.70.	Quarter 1 - 2012
	3.71.	Quarter 1 - 2012
<b>Primary Care Services</b>	3.72.	
	i.	Quarter 3 - 2011
	ii.	Quarter 4 - 2011
<b>Hospital Services</b>	3.73.	Quarter 3 - 2011
	3.75.	Quarter 3 - 2011
	3.78.	Quarter 1 - 2012
	3.79.	Quarter 1 - 2012
	3.80.	Quarter 2 - 2012
	3.81.	Quarter 2 - 2012
	3.84.	Quarter 1 - 2012
<b>Regional Health Authorities</b>	3.85.	Quarter 4 - 2012
<b>Cross Services</b>	3.86.	Quarter 2 - 2012
	3.87	Quarter 3 - 2011

SOURCE: Adapted from European Commission - The Economic Adjustment Programme for Portugal, 2011

It is plain to see, that many of the measures proposed by the government and the *Troika*, intend to cut in the health expenditure, aiming to cost-containment in order to try and make the Portuguese health care system more efficient. But if the cuts made are not carefully planned, we can, in the long term, destroy the NHS as we know it.

The necessity of effectively reducing the health expenditure is already being implemented with new health laws. Unfortunately even if the measures are written as orders implementing the law, many of them are based on a medium or long-term. Furthermore the more effective ones at a short term place a heavy burden in the Portuguese citizens.

As Reich (2011) noticed, a major concern about universal coverage is how to control health expenditures in a sustainable manner (Reich, 2011).

A description of the Portuguese health system was made through the past chapter. The legal framework, the organization, the new measures being implemented, all of these were covered. The next chapter is dedicated to the new health reform in the US, the Patient Protection and Affordable Care Act.

## 5. U.S. Health Care Reform

*“The possibility of Federal reform remains a perennial goal – tantalizing to some, anathema to others.” (Mariner, 2007)*

The year 2010 was of tremendous importance for the health care sector in the US. The 2008 election of Barack Obama as President presented a new opportunity to reform the US health care system. The last time that health reform was an important national policy goal was in the Clinton Administration, which proposed the Health Security Act in 1993.

Presidents Nixon, Truman, and Kennedy championed national health insurance briefly, and President Clinton even attempted a national health reform incorporating private insurance in 1993, all without success (Starr, 2011).

However, as mentioned by Zelman (1994), the debate on health care reform proposals during the Clinton administration tended to focus on the problems, concerns and differences that the health care reform would raise rather than on similarities, areas of agreement and the potential for coalition building and compromise (Zelman, 1994).

The Clinton administration's Health Security Plan began with a goal that the majority of European Countries took for granted: a universal health care system. It was assumed at the time that health care coverage for all would produce better health and well-being for the society as a whole. To the fundamental guarantee of coverage and security for all, former President Bill Clinton added five other guiding principles: savings; choice; quality; simplicity, and responsibility. This reform recognized that only the national government could guarantee universal coverage (Zelman, 1994).

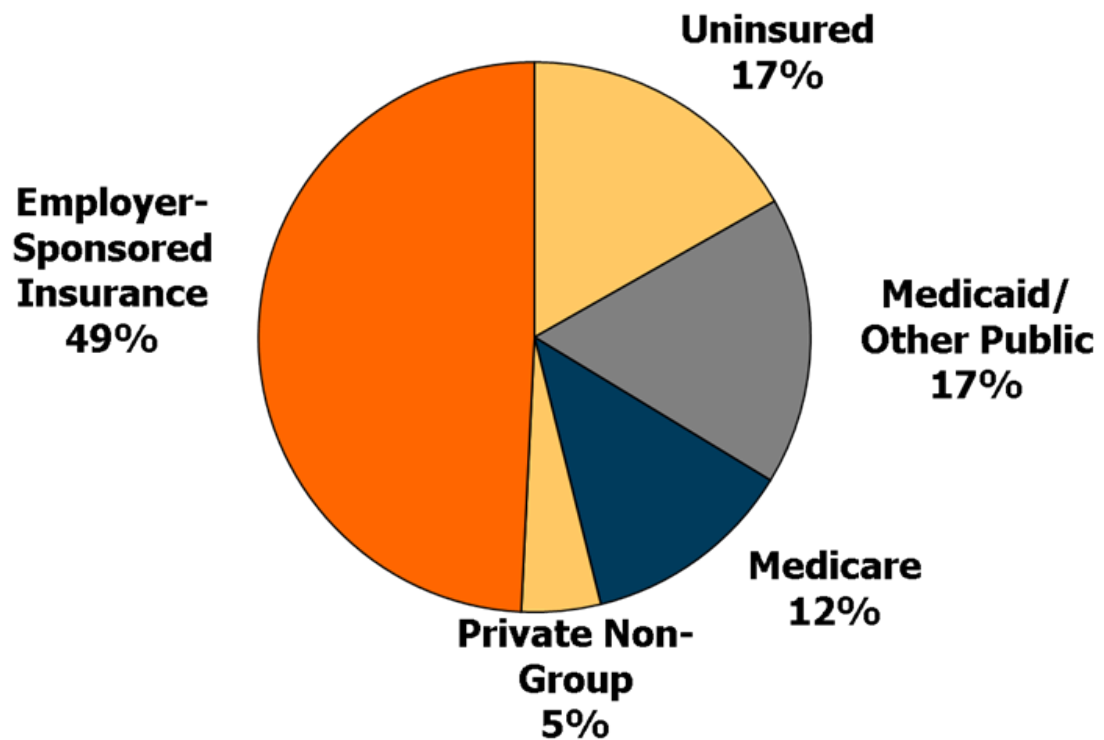
Quoted by Charles Barnes (2007), in 1997, Kuttner stated that, despite the fact a significant proportion of the US population were denied access to healthcare, this state of affairs was considered unacceptable by the public. Yet, after September 11, 2001, the federal policy shifted away from providing public services in order to concentrate on national security and terrorism (Charles Barnes, 2007; Faria, Mariner & Annas, 2009).

But the problem with the uninsured continued and public attention returned to the problem more than a decade after the failure of the Clinton proposal. In June 2003, excluding Medicare, health care was considered to be the third most important issue for the government to address, according to public opinion surveys. Demand was increasing for some kind of health care reform that would allow access to a basic level of health care to the poor, who were priced out of the market (Charles Barnes, 2007).

Even so, American citizens were less supportive of a major reform than they were for incremental proposals for reducing the number of uninsured (Blendon, Benson & DesRoches, 2003). In April 2006, the State of Massachusetts enacted a comprehensive health reform law that changed the view of health care in the US. The main goal of this law was to provide affordable health insurance to all of its uninsured legal residents (Mariner, 2007).

Still in 2009 and with a population of 303.3 million citizens the percentage of uninsured was significant. The graphic below represents how health insurance was distributed in the US in the year 2009.

**Figure 5.0-1: Health Insurance Coverage in the US, 2009 (Total = 303. million)**



NOTE: Includes those over age 65. Medicaid/Other Public includes Medicaid, CHIP, other state programs, military-related coverage, and those enrolled in both Medicare and Medicaid (dual eligibles).

SOURCE: Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on the Census Bureau's March 2010 Current Population Survey. [www.kff.org](http://www.kff.org)

With such an inequitable system and after the failure to enact President Clinton's Health Security Act, President Obama initiated a revolution in the health care sector by proposing what became The Patient Protection and the Affordable Care Act.

Before getting into the ACA it is important to stress 3 phases in the American health care system. The first one between 1900 and 1965 represents "the coming of age of American

medicine” in which scientific advances initiated an expanding supply of promising care. The second one ranged from 1965 until 1985, when insurance became an established financing method and costs rose in the wake of public programs (Medicare and Medicaid). And finally the third phase, it started in 1985 and is, probably, still going on, where regulatory efforts subsided while an entrepreneurial ethos reshaped traditional relationships (Mariner, 2007).

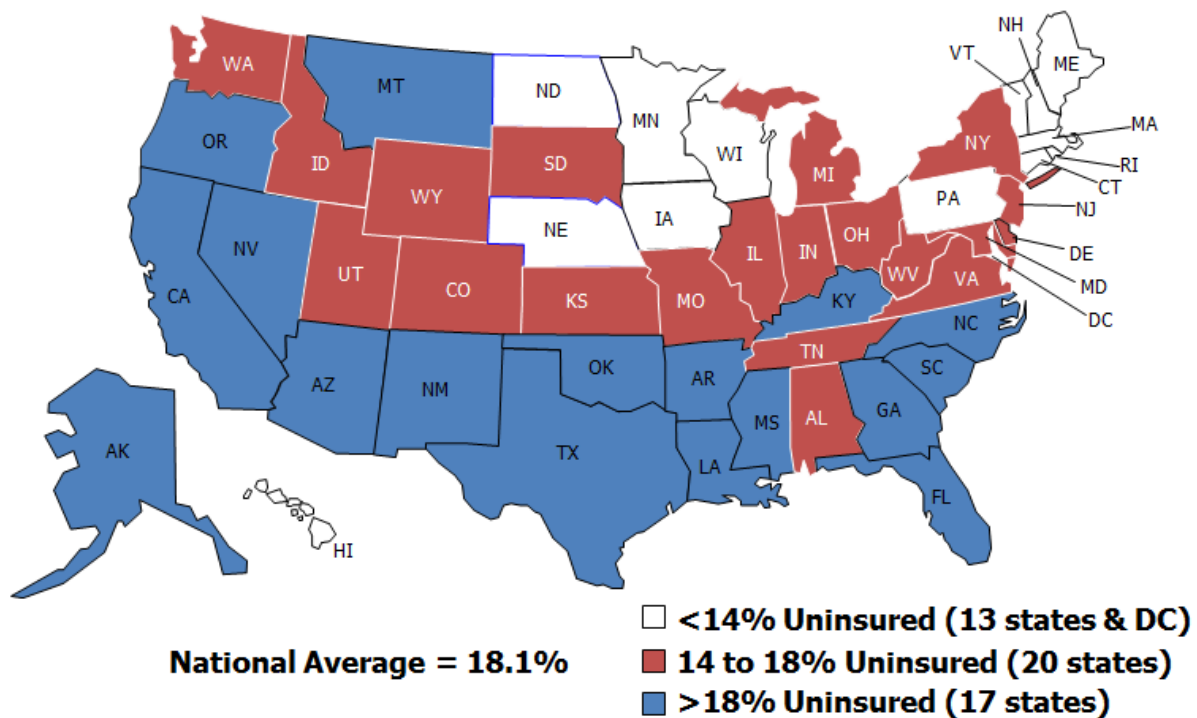
Bearing these three phases in mind is essential to comprehend that in the past, most health care reforms in the US failed, mainly because of the industry interests’ resistance. The 2009-2010 battle was notably different. Many of the traditional opponents, including the principal lobbying groups for doctors, hospitals, and insurers, either publicly promoted the reform or stayed on the sidelines (Kersh, 2011). Also, the insurance industry was losing market share among employers, who were consistently covering a lower percentage of their employees. The idea of requiring individuals to have insurance opened up a new market for the private insurance of perhaps between 10 and 20 million citizens. The ACA managed to bring a spirit of union among different groups, something that past reforms have failed to accomplish.

The primary goal of the Affordable Care Act is to give almost all American access to health care by making private insurance both affordable and available to all and increasing eligibility for public insurance (Mariner, 2010).

However coverage and implementation will probably be uneven across states, and in an era of fiscal constraint the political battles will almost definitely slow down or derail certain provisions of the ACA (Jacobs, 2011).

The Graphic below exemplifies how the uninsured were spread across the States in the US in the years 2008 and 2009 among the nonelderly population and how, probably, certain provisions of the ACA will be difficult to implement in certain states regarding the uninsured.

**Figure 5.0-2: Uninsured Rates among Nonelderly by State, 2008-2009**



SOURCE: Kaiser Commission on Medicaid and the Uninsured/Urban Institute analysis of 2009 and 2010 ASEC Supplements to the CPS., two-year pooled data.

## 5.1 The Patient Protection and the Affordable Care Act

*“The core principle that everybody should have some basic security when it comes to their health care”* – President Obama after signing the ACA (Mariner, 2012b)

The ACA employs five main tools to reduce the number of uninsured:

1. Comprehensive reforms of private insurance, which alter private insurers' underwriting practices, guarantee issuance of coverage, overhaul of private health insurance products and restrict the premium pricing structure;
2. Creation of state-run “Health Benefit Exchanges” as new marketplaces through which individuals, families and small employers can competitively purchase new private insurance products and obtain federal tax credits and subsidies to do so;
3. A mandate where individuals must purchase and continuously maintain health insurance or pay annual tax penalties;
4. Penalties on private employers who do not offer at least some type of health plan, with minimum standards of coverage, to their employees;

5. The expansion of eligibility for Medicaid, a public program for low-income groups, to include all low-income adults under 65 years of age, with increased federal subsidies for the newly eligible population.

(United States Court of Appeals for the Eleventh Circuit, 2011)

Quoted by Morgan and Campbell (2011,) regarding the ACA in 2010 Boehmer considered that it represented a massive “takeover” of the health care sector by the federal government (Morgan & Campbell, 2011).

As noted by Mariner, Annas and Glantz (2011) the federal government has never exercised its authority to require individuals to buy insurance, although it has exercised its authority to regulate insurance companies and their group policies. Under the Commerce Clause of the American Constitution the federal government has the authority to regulate the insurance industry (Mariner, Annas & Glantz, 2011).

Notwithstanding many of the ACA goals are pursued with only a limited increase in federal governing authority (Morgan & Campbell, 2011).

The US is a Federal Republic, and its authority is divided between the national government and the states but it does not divide it consistently on the basis of general principles (Starr, 2011).

By providing federal money and rules the ACA tries to correct historical and regional inequalities in the American health care system. Using the money to cover the remaining uninsured and the rules to encourage the states to cover all the poor and to insure the pooling of risk in the private individual and the small-group insurance markets, which will limit the cost of subsidies needed to help citizens afford that coverage (Starr, 2011). The Federal government does not have the power, under the US Constitution, to compel the states to enact state laws, including laws to cover all the poor and insure the pooling of risk in the individual and the small-group insurance markets. The federal government can, however, offer the states money with conditions. The States can choose whether or not to accept this offer. If the States do not create health insurance exchanges, the ACA allows the Federal government to create a Federal Exchange. Concerning Medicaid the Federal Government will not make the newly eligible part of a new Federal program; instead, it will pay the States 100 percent of the cost of adding the new eligible to the State Medicaid program.

Even so American citizens have contradictory and ambivalent opinions regarding governmental authority. They simultaneously desire social programs and view federal government with suspicion (Morgan & Campbell, 2011).

Starr explains that the main thrust of the ACA is to change how health insurance works, making it affordable and implementing at the same time measures to improve the quality of care and cost-containment. There are few direct cost-containment requirements, but there is considerable federal funding to create experiments to figure out how to lower the rate of cost increases. On the other hand the organization of the medical care is not altered substantially and, in the long-run, by itself, the ACA may not significantly alter the trajectory of health spending (Starr, 2011).

This law rewrites the rules of the insurance market providing affordable means of financing health care for all American citizens and at the same time preserving the private, commercial health insurance industry (Starr, 2011; Mariner, Annas & Glantz, 2011).

The former rules of the insurance market allowed insurers to refuse to sell policies to anyone, and insurers had financial incentives to avoid individuals that represented high health costs (Starr, 2011).

The ACA changes that; it prohibits insurers from refusing coverage to any American citizen or legal resident, even those with pre-existing conditions, from rescinding coverage because of illness or charging according to an individual's health, i.e., charging citizens who are in poorer health premiums much higher than average. It also requires insurers to issue policies and renew them for all legal applicants. This regulation of the health insurance market is, by all means, a constitutional exercise of the Congress's power under the Commerce Clause (Starr, 2011; Mariner, Annas & Glantz, 2011). Quoting the Supreme Court decision in the case *United States v. Southeastern Underwriters Association, Inc.*, 322 U.S. 533 (1944): *"No commercial enterprise of any kind which conducts its activities across state lines has been held to be wholly beyond the regulatory power of Congress under the Commerce Clause. We cannot make an exception of the business of insurance"* - case *United States v. Southeastern Underwriters Association, Inc.*, 322 U.S. 533 1944 (Justia, 2011).

Illness is the leading cause of personal bankruptcy in the US, even among the insured individuals (Rodwin, 2011). Besides, as reported by the Institute of Medicine (IOM) in 2001, there is substantial evidence that citizens that lack access to health care or insurance coverage have a higher risk of disability and death, when compared to the general population (Institute of Medicine, 2001).

*"Expanding access to health care to the entire population [...] is the socioeconomic equivalent of vaccination against disease"* (Faria, Mariner & Annas, 2009).

Hence the ACA objective is to provide access to health care and protection against the risk of being bankrupted by medical costs, but unlike Britain's or Portugal's National Health

Service (NHS), the legislation does not make health care free at the point of service, and unlike the Canadian National Health Insurance system, it does not make health insurance a right. It seeks the more limited goal of making health care and health insurance “affordable” (Starr, 2011).

Obama's health care reform inaugurates a new redistributive process that makes possible for every American citizen to either buy affordable insurance or qualify for free public insurance, mainly the Medicaid Program.

The Congressional Budget Office (CBO) expects to boost insured citizens from 83% in 2010 to 94% of the population by 2019 (Jacobs, 2011; Rodwin, 2011). In other words, to increase the number of insured and enable low-income people to comply with the mandate, where an individual and any dependent is required to maintain a minimum level of coverage (USA Federal Statute, 2010), the law extends eligibility for Medicaid to all citizens with incomes under or near the federal poverty line and subsidize private insurance for both citizens and legal immigrants earning between the poverty level and four times the poverty level (Starr, 2011).

The ACA also introduces a shift in the financing of health insurance for the nonelderly citizens. It uses federal government authority to compel employers, with more than fifty employees, to offer adequate coverage or to pay a penalty for employees who receive tax credits for health insurance. It also requires that employers pay a minimum share of their employees' insurance premiums, imposing a penalty for those who do not (Jacobs, 2011).

Formerly, the law did not force the employers to secure health coverage to its employees. The companies could, at their discretion, withdraw part of the benefits in health care or even the whole from its employees without them having any opportunity to appeal such decision (Faria, 2004).

Jacobs and Skocpol (2010) refer to this legislation as, *“the first national effort to ensure access to the nonelderly population, extending insurance coverage to 32 million people”* (Jacobs, 2011).

The ACA tries to make the US health care system similar to most European universal health systems such as the Portuguese NHS.

As Okma (2002) mentioned, in the last quarter of the twentieth century European citizens expected and accepted government intervention to make sure everyone has access to health care via state-sponsored or state provided arrangements. Europeans see universal access to health care as a social right, a crucial element of a decent society (Okma, 2011). This is not



only seen by the Portuguese citizens as a crucial element of a decent society but as fundamental right of our Democracy, stated in Article 64 of the CRP and that no government can deny to its citizens, no matter the cost.

But as Mariner (2010) remarked, unlike in the US, many of the western Europeans countries adopted “social insurance” schemes of health care before the commercial insurers could secure a more prominent place of the market in private policies (Mariner, 2010).

Still, it is interesting to see how the perspective of William Beveridge, the founder of Britain's national health insurance system and the one used in the making of the Portuguese NHS, has special resonance in the American health care reform, the ACA (Mariner, 2010).

However in order to cover everyone, the contributions need to be compulsory, which only the State, as a nation or in case of the US the Federal government can require that is why with state-level rather than national insurance exchanges, the success of the reform, from patient access to insurance to cost control – hinges on state action (Mariner, 2010; Morgan & Campbell, 2011). In the ACA, Congress could have decided that all Exchanges would be Federal. Instead they gave the states some latitude allowing them to create their own Exchanges. If a State does not create an exchange then the Federal government will. There is no legal reason for this choice so the Congress probably chose it for historical and political reasons, mainly:

1. Traditionally the states have regulated insurance companies even though the Federal government has the constitutional authority to do so (and has done so to some extent in earlier statutes like Health Insurance Portability and Accountability Act and Employee Retirement Income Security Act);
2. Many members of the Congress ideologically prefer the states to retain some power even in areas where the Federal government could take complete control.

Furthermore, relatively little money was budgeted for the implementation of the ACA, and with complex reforms as this one, it is a requirement to have able administrators, timely rule making, and effectively the oversight of the many agents involved (Morgan & Campbell, 2011).

Thus the law depends heavily on the state government to do the work of overseeing private insurers, even though state capacity for insurance regulation is highly variable (Morgan & Campbell, 2011).

Overall, it is important to stress that in order to be fully implemented the ACA requires the coordination of federal and state level government officials along with hundreds of affected

parties (Kersh, 2011). The President's power is in a way, bounded by political institutions that make major change very difficult, if not impossible (Okma, 2011). For Portuguese citizens it is difficult to understand the massive effort to implement something they take for granted, but it is also interesting to notice that a shift may be on the verge of happening in health care access in the US.

## 5.2 Health Insurance Companies

*“Insurance broadly defined is simply a form of risk shifting and risk spreading among persons”* (Fischer, Swisher & Stempel, 2001).

Insurance is, by all means, the quintessential tool for spreading and managing risk (Mariner, 2012b).

As mentioned by Fischer, Swisher and Stempel (2001) since the New York Armstrong Committee investigations of 1905-1906 the insurance business has been heavily regulated. This was done with two purposes in mind, promoting a fair business practice and maintaining insurer solvency (Fischer, Swisher & Stempel, 2001).

Therefore insurance law is a hybrid mixture of private contractual law and state statutory law, and increasingly, Federal statutory law where the regulators try to control the substantive terms of the insurance policy in order for the insured to enter into a fair and equitable contract (Fischer, Swisher & Stempel, 2001).

In contrast health insurance can be, and to a large extent already is, a separate species of insurance. The regulation and industry practices already have moved health insurance into becoming an identifiably separate species of insurance by limiting some risk classification methods common to the indemnity insurance (Mariner, 2010).

As noticed by Mariner (2010) most reform proponents discuss insurance as though it were simply a mechanism of financing health care. Health insurance is simply a mean to an end: appropriate yet affordable health care regardless of employment, residence, health status, age or any other factor that could inhibit access (Mariner, 2010). Furthermore, health insurance is not typically designed to improve the policyholder physical or mental wellbeing; however, it does play a significant role in shaping public attitudes toward responsibility for health risks (Mariner, 2012b).

As it is stated in article 25 of the Universal Declaration of Human Rights *“everyone has the right to a standard of living adequate for health and well-being of himself and of his family,*

*including (...) **medical care***” (United Nations, 1948). Also article 3 – Equitable access to health care from Chapter I – General Provisions of the text of the Oviedo Convention states that “*parties, taking into account health needs and available resources, shall take appropriate measures with a view to providing, within their jurisdiction, equitable access to health care of appropriate quality*” (Council of Europe, 1997)

As Mariner stated (2010) most of the tools that the private insurance industry traditionally used are incompatible with the goals of universal coverage, which is precisely what the ACA tries to accomplish. Bearing this in mind, the ACA plans to pay for health care in ways that necessarily limit the scope of the conventional insurance techniques. President Obama and the members of Congress emphasized that the legislation should prohibit insurers from classifying people according to their risk in order to refuse coverage or greatly increase insurance premiums (Mariner, 2010).

However and as is stressed by Mariner (2010), even this hybrid species of health insurance is not likely to be universally affordable in the US without ensuring participation by virtually all American citizens. For this reason, the ACA requires individuals to obtain insurance, and subsidizes low-income individuals who cannot afford premiums (Mariner, 2010).

Permissible insurance coverage can be from public or private programs. The Table below shows how health insurance was distributed in the US before the ACA among the nonelderly population (under 65 years old). The remaining population (those 65 years and older) are covered by Medicare, the federal government program.

**Table 5.2-1: Nonelderly Population with Selected Sources of Health Insurance Coverage, 2009**

Coverage	Number (millions)	Percentage
TOTAL (Nonelderly)	264.7	100.0%
Employment – based	156.1	59.0%
Individually Purchased	16.7	6.3%

Public	56.0	21.1%
* Medicare	7.3	2.8%
** Medicaid/CHIP	44.1	16.7%
Tricare/CHAMPVA	8.3	3.1%
No health insurance	50.0	18.9%

\* Total population in Medicare (+65 years), not included here: 46 million

\*\* Medicaid as of February 2010: 50 million

Note: The total US population including the elderly in 2009 was about 300 million. Today, the population is about 312 million (<http://quickfacts.census.gov/qfd/states/00000.html> )

SOURCE: Fronstin, P. - Sources of health insurance and characteristics of the uninsured: analysis of the March 2010 Current Population Survey, 2010

As we can see almost 60 percent of the nonelderly population in the US had employment based insurance before the ACA.

The ACA's regulation of health insurers to monitor whom they cover, the benefits they offer and other aspects reverses the previous presumption of deference to the private business prerogatives and stands as a beacon of the wider boundaries for what is considered appropriate for public decision making (Jacobs, 2011).

Since the enactment of the ACA the private insurance companies will find that their decisions about premiums increases are more regularly subjected to public review, especially when a government official declares them "unreasonable". Insurers are now prohibited from refusing to cover preexisting medical conditions, refusing citizens coverage because of their medical history, dropping coverage after illness occurs, discriminating on basis of health status, discriminating in benefits on the basis of age or disability, charging much higher premiums on the basis of age, providing less coverage for mental health and substance abuse disorder benefits than for medical conditions, capping the dollar amount of coverage, charging high out-of-pocket expenses, and the amount of premiums devoted to medical care will be publicly scrutinized to determine if 80 percent or more is devoted to clinical services and activities that improve the quality of health care, if not, the insurance companies must pay rebates to insured customers (Mariner, 2010; Jacobs, 2011).

All these prohibitions remove risk classification tools regarded by the insurers as essential to permit underwriting in conventional insurance. So what the ACA leaves from the conventional insurance is the risk rating, i.e., setting premiums according to risk profiles of

the whole group covered by a policy and not a single individual (Mariner, 2010). However any federal changes to rating or issuances rules will affect every state in a different way, especially on premiums, current policy, policy holders, and the uninsured (Lineham, 2009). This occurs because every state has different rules for insurance companies, some are highly regulated and others are not. With the ACA insurers in all states are bound by the Law to comply with federal rules which are much more stringent than most state rules. Furthermore the ACA will provide funding to help the states to create new systems to review the premium rates of insurers. The states that already possess strong rate regulation rules will not have to change much, but other states will have to create new or better rate regulation systems if they want the funding provided by the ACA.

Treating health insurance differently from the conventional insurances requires adjusting some traditional statutory and legal doctrines that underpin insurability, coverage, and contract interpretation (Mariner, 2010). This way health insurance can occupy, as observed by Mariner (2010), a conceptual space between the conventional insurance and consumer transactions, with financing health care as its main goal (Mariner, 2010).

But if health plans, being public or private, are required to accept anyone who applies and premiums must be affordable to all, then high risk populations will need to be subsidized or granted access to reinsurance in order for the premiums to maintain their competitiveness across the market. This can be done, possibly, by financing it with taxes on individuals or on health plans with healthier populations (Mariner, 2010). Since the ACA requires everyone to have coverage (individual mandate), there is no need to apply taxes on individuals or on health plans with healthier populations.

### 5.3 Private Insurance and Exchanges

*“In a world that is perfectly ordered, controlled, and determined, insurance has no meaning”*  
by Thomas Morawetz (Mariner, 2010)

Bearing in mind how the Insurance companies need to alter their former perspective on what should be a health plan/insurance, it is important to understand what the sources of health care payment are. The table below sheds some light on the subject.

Table 5.3-1: Sources of Health Care Payments, 2012

Federal	Federal/State	State	Private Insurance
Medicare	Medicaid/CHIP	High Risk Pools	Employer:
Department of Defense		Reinsurance	[Private/Government]
Veterans Health Service			Large group
Tricare			<ul style="list-style-type: none"> <li>Insured</li> </ul>
Indian Health Service			<ul style="list-style-type: none"> <li>Self-insured</li> </ul>
			Small group
			Non-group/individual

Note: this table describes the situation before the ACA takes effect in 2014

SOURCE: Mariner, W. – Class presentation in health reform, health insurance and the law, 2012a

It is plain to see that the US relies heavily on private insurance (merely 21.1 percent of the nonelderly population has public insurance, if we add the elderly population covered by Medicare the percentage becomes closer to 34 percent of the population) which, accordingly to Rodwin (2011), uses 15 to 20 percent of premiums for administration and profit, costing much more than public insurance. It is important to notice that the government also pays private insurance to cover their employees and although this is not public insurance the government is paying almost half of the cost of health insurance even if some of it is paid to private insurance companies (Rodwin, 2011).

Private insurance, especially group insurance, financed through employment, ultimately prevailed for the great majority of the population (Klees, Wolfe & Curtis, 2011).

In the private insurance there are different sources of health care payment: employers that can be large groups (and have two types of insurance: insured or self-insured) or small groups and non-group/individual. Regarding the large groups, fully insured employers buy a private insurance group policy for their employees. The self-insured employers design their own benefit plans and use their own money to pay for it.

Non-group insurance is defined by an individual purchasing a policy for himself or for his entire family through insurance agents or brokers, online clearinghouses, or directly from insurance companies, rather than as a member of a group/employer (Lineham, 2009).

Before the ACA, the regulation of non-group health insurance markets was largely the province of states and its market was prone to adverse selection because seeking coverage was voluntary and initiated by the individual, who had better information about his health than the insurers did. The variation in the non-group market affected the number of people enrolled, the risk profile of those with coverage, the comprehensiveness of coverage, and premiums paid in each state, so the states' law and regulations related to the underwriting and other practices of the non-group market reflected an attempt to balance the access and affordability of its products (Lineham, 2009). The individual and non-group policies were underwritten so the premium paid was based on the actual health risks of the individual. This led to high risk citizens being charged very high premiums because the risk could not be spread across the group. For the aforementioned reasons individuals with health problems could not afford to buy insurance so the non-group market consisted mostly of healthy individuals.

The small group is a term that refers to the market in which individuals purchase coverage through a group plan sponsored by a small employer or an employer that has no more than 100 employees (United States Court of Appeals for the Eleventh Circuit, 2011). States can, however, define the maximum number of employees differently; 50 employees also a common maximum.

It is not common for small group/small firms to offer health care insurance to its employees. The main reasons are (Hearne, 2005):

1. Some small employers are not able to undertake the many complex tasks required to offer health care insurance as a benefit. Complex tasks include reviewing plans, negotiating terms of the contract with health insurers, administering the benefits, and collecting and paying premiums;
2. Conditions of the labor market may make health insurance unnecessary for attracting workforce for certain employers. If the workers are scarce, offering health insurance becomes desirable, but if the labor is plentiful there is no incentive to offer health insurance since even without such a benefit workers are still available;
3. Demand for insurance among small business workers may be low relative to workers in large companies;
4. Some small employers cannot meet the minimum enrollment requirement demanded by insurance companies;

5. Risk-spreading: the costs of the same benefits are likely to be higher for small groups than for larger groups because these small firms lack a large group of workers to spread the risks among and because the administrative cost of dealing with many small firms is higher relatively to the costs of fewer larger firms.

As it is stated in the ACA, by January 1 of 2014, all states must establish “American Health Benefits Exchange” and “Small Business Health Options Program Exchanges (SHOP)”. The Exchange represents insurance marketplaces where individuals, families, and small employers can shop for the Act’s new insurance products (United States Court of Appeals for the Eleventh Circuit, 2011). Some states may have a combined exchange that offers both individual and small business insurance, and not have a separate SHOP exchange.

States have until November 16 of 2012 to notify the Department of Health and Human Services (HHS) whether they want a state Exchange, a partnership Exchange, or a Federally Facilitated Exchange (FFE). If a State does not have a State Exchange or a Partnership Exchange operable by January 1, 2014 the HHS will establish a FFE for each State (this will be determined by January 1, 2013) (Jost, 2012).

The HHS also offers 4 principles for the FFE articulated by a guidance they released. The aforementioned principles are (Jost, 2012):

1. Ensuring that citizens in all 50 States have access to high-quality, affordable health coverage options through an Exchange and experience a positive and seamless consumer experience;
2. Establishing parity in markets inside and outside the Exchange and minimizing burdens on insurers while protecting consumers;
3. Building on state policies, capabilities, and infrastructure to the extent a State permits;
4. Engaging with the States and with local stakeholders in each state to inform and support decision-making.

Regarding the partnership Exchanges, the HHS guidance describes them as Exchanges in which the Federal government runs and is responsible for the Exchange but the State takes responsibility for either plan management, consumer assistance, or both (Jost, 2012).

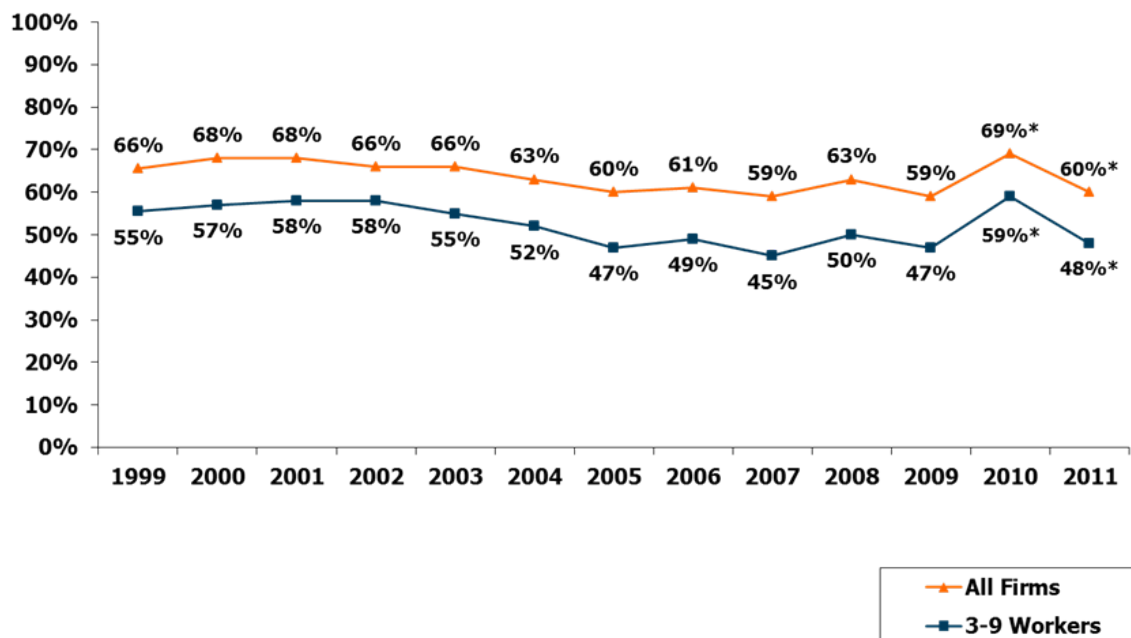
When we speak about large groups the insurance offered can be insured or self-insured. The insured is easy to understand, because it is like buying any insurance policy. The employer buys a group health policy from a private insurance company and the employer and the employee pay the insurance company monthly premiums.



But a self-insurance/self-funding employer group health plan represents a health care benefit that is offered by an employer or a group of employers, like an association or a trade group. It is self-funded or self-insured when the employer sets aside its own funds to cover the cost of health benefits for their employees instead of purchasing an insurance plan from traditional insurance companies or a health maintenance organization (HMO) (Hearne, 2005). Instead of the insurance company assuming the risk of the employees in health matters it is the employer bearing the risk.

The percentage of all companies (small or large) offering health care benefits is steadily decreasing in the last decade in the US as shown in the graphic below (2010 represents an outlier in this behavior).

**Figure 5.3-1: Percentage of All Firms Offering Health Benefits, 1999-2011**



\*Estimate is statistically different from estimate for the previous year shown ( $p < .05$ ).

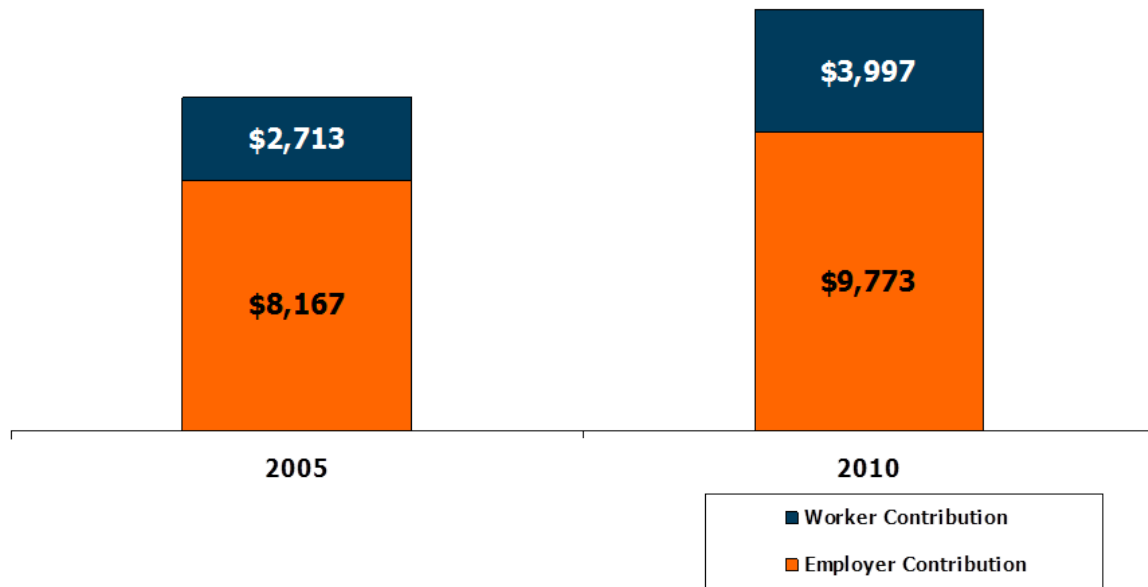
Note: Estimates presented in this exhibit are based on the sample of both firms that completed the entire survey and those that answered just one question about whether they offer health benefits. The percentage of firms offering health benefits is largely driven by small firms. The large increase in 2010 was primarily driven by a 12 percentage point increase in offering among firms with 3 to 9 workers. In 2011, 48% of firms with 3 to 9 employees offer health benefits, a level more consistent with levels from recent years other than 2010. The overall 2011 offer rate is consistent with the long term trend, indicating that the high 2010 offer rate may be an aberration.

SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2011. [www.kff.org](http://www.kff.org)

Still, with the financial crisis that has swept most of the western countries, the amount of contribution from the companies to health care coverage has also decreased, while the amount of premiums paid by employees has increased.

Employees pay 47 percent more in 2010 than they did in 2005 for the family health care coverage they got through their jobs, while their wages have increased only 18 percent. In contrast, employers pay 20 percent more toward their employees' health insurance than they did five years ago (Mariner, 2012a).

**Figure 5.3-2: Average Annual Health Insurance Premiums and Worker Contributions for Family Coverage, 2005 vs. 2010**



Note: The average worker contribution and the average employer contribution may not add to the average total premium due to rounding.

SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2005-2010.

The health care exchanges created by the ACA for the small groups and non-group/individuals will not regulate policies obtained through an employer or large group in the beginning, but eventually they will. Employers can maintain their current plans, which are called “Grandfathered plans”, if they comply with a few ACA requirements. An example of these requirements is allowing families to keep their children under the family plan until age 26. If major changes are done to the plans in the future, the plans will no longer be grandfathered and the employer must comply with the ACA rules. Eventually all employers need to change their plans so the grandfathered status is temporary.

Although the ACA will make major changes in the American health care four problems will still plague the US health system according to Rodwin (2011):

1. Access to insurance outside of the exchange does not ensure adequate coverage or access;

2. Paying for insurance is going to burden the low and middle-income American citizen failing to prevent economic hardship or ruin from illness;
3. The US still lacks the means to effectively control spending increases which ultimately erode coverage and raise premiums;
4. The financial conflicts of interest distort medical care practice (Rodwin, 2011).

Concerning point 2, it is important to stress that the ACA is not supposed to burden the low-income groups, since these are eligible for Medicaid or for subsidies that allows them to buy private insurance. It may burden some low and middle-income families that are not eligible for a subsidy (which will cause the insurance premiums to rise). Even so, that will not likely create ruin from illness but it may lead to some economic hardships.

#### 5.4 Medicare and Medicaid

*“Medicare: we care for our old; Medicaid: we aid our poor”* (Students use this Mnemonic in class to distinguish the two US programs)

In the year 1965, Congress passed legislation establishing the Medicare and the Medicaid programs as Title XVIII and Title XIX, respectively, of the Social Security Act. While Medicare was established in response to the specific medical care needs of the elderly, Medicaid was established in response to the widely perceived inadequacy of welfare medical care under public assistance. In 1973 coverage for certain American citizens with disabilities and persons with kidney disease were added to the Medicare program (Klees, Wolfe & Curtis, 2011).

Medicare, is also designated as “Health Insurance for the Aged and Disabled”. Initially Medicare was consisted of two parts: Part A also known as Hospital Insurance and Part B also designated as Supplementary Medical Insurance. Part A comprehends inpatient hospital, home health agency, skilled nursing facility, and hospital care; it is provided by the federal government free of premiums to most eligible people. Certain ineligible people may voluntarily pay a monthly premium for coverage. Part B helps pay for physicians, outpatient hospital, home health agency and other services. In order to be covered by Part B, all eligible people need to pay a monthly premium or have the premium paid in their behalf (Hall, 2011; Klees, Wolfe & Curtis, 2011).

In 1997 the Balanced Budget Act (BBA - Public Law 105-33) created a third part of the Medicare, Part C which is the Medicare Advantage program. In 2003 this program was renamed and modified by the Medicare Prescription Drug, Improvement and Modernization

Act (MMA - Public Law 108-173) (Hall, 2011; Klees, Wolfe & Curtis, 2011). It creates an alternative to Parts A and B. It authorizes the federal government to pay private HMOs or managed care insurance companies to provide coverage to Medicare participants for services covered by Parts A, B and D

In order to help pay for prescription drugs not covered by Part A or Part B, the MMA established a fourth part of Medicare, Part D. In 2006 and after, Part D provided access to prescription drug insurance coverage on a voluntary basis for all beneficiaries upon payment of a premium. For low-income enrollees it provided premium and cost-sharing subsidies (Hall, 2011; Klees, Wolfe & Curtis, 2011).

Medicare Parts A and B pay providers on a fee for service basis. All financial operations for Medicare are handled through two trust funds, that represent special accounts in the US Treasury, one for Hospital Insurance (Part A) and one for Supplementary Medical Insurance (Parts B and D). Medicare beneficiaries are free to buy private insurance that covers, within limits, most of the health care service charges that are not covered by Part A or B. Those private health insurances are denominated by term “Medigap” (Hall, 2011; Klees, Wolfe & Curtis, 2011).

It is important to note that the Medicare program covers about 95 percent of the US aged population as well as many younger citizens who receive Social Security disability benefits, i.e., people who are disabled; it is also the largest health care insurance program and the second largest social insurance program in the US (Hall, 2011; Klees, Wolfe & Curtis, 2011).

Medicaid is a Federal/State entitlement program that pays for the medical assistance of individuals or families that possess low income resources. Nonetheless if the states want to be eligible for federal funds, they are required to provide Medicaid coverage for certain individuals who receive income maintenance payments as assistance from the Federal government, as well as for related groups who do not receive cash payments. However many states who possess additional “state-only” programs that provide medical assistance for specific groups of low income citizens, do not meet the requirements needed to be part of the Medicaid Program (Hall, 2011; Klees, Wolfe & Curtis, 2011).

States can determine the amount and the duration of the services they offer under their Medicaid program, they only have two restrictions:

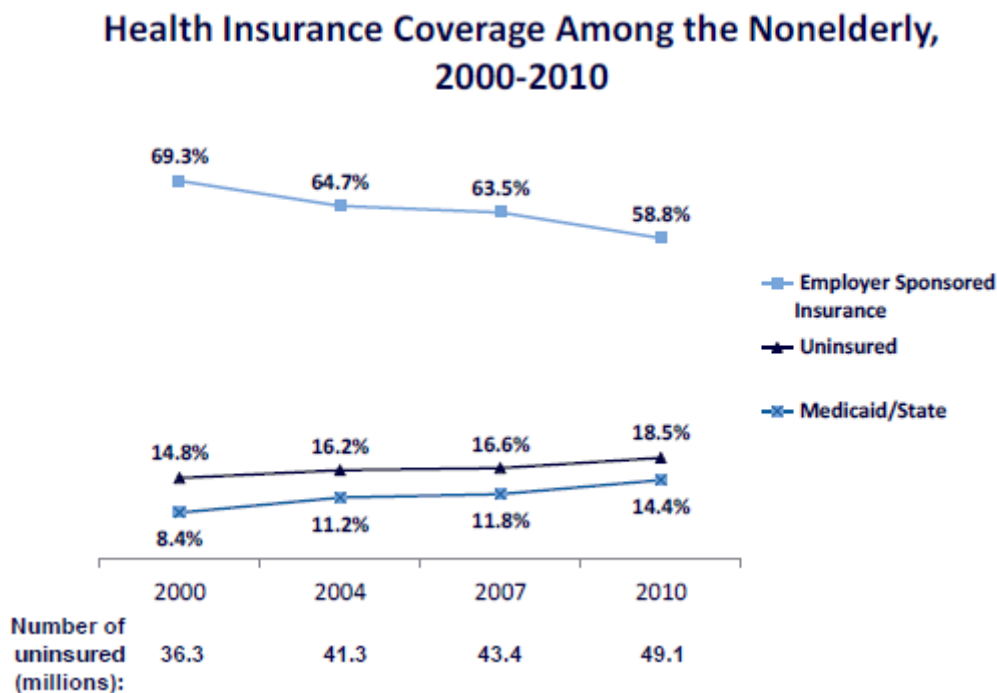
1. The limits must result in a sufficient level of services that can achieve, reasonably, the purpose of the benefits;
2. The limits on benefits may not discriminate among the beneficiaries based on their medical condition or on medical diagnosis.

The majority of the beneficiaries from the Medicaid program incur a relatively small average expenditure per person each year, and only a relatively small proportion, mainly people with severe disabilities or in nursing homes, incur on very large costs. Beneficiaries enrolled in both Medicare and Medicaid have many services paid for by Medicare before any payments are made by the Medicaid program since Medicaid is always the “payer of the last resort”. It was estimated by the Centers for Medicare & Medicaid Services that in 2010 Medicaid would provide some level of supplemental health coverage for about 9.1 million Medicare beneficiaries (Hall, 2011; Klees, Wolfe & Curtis, 2011).

As stated by Holahan and Chen (2011) in 2010, the number of uninsured nonelderly American citizens reached over 49 million, an increase of nearly a million citizens when compared to 2009 (Holahan & Chen, 2011).

In the graphic below is possible to see the behavior of health care insurance coverage among the nonelderly population between 2000 and 2010.

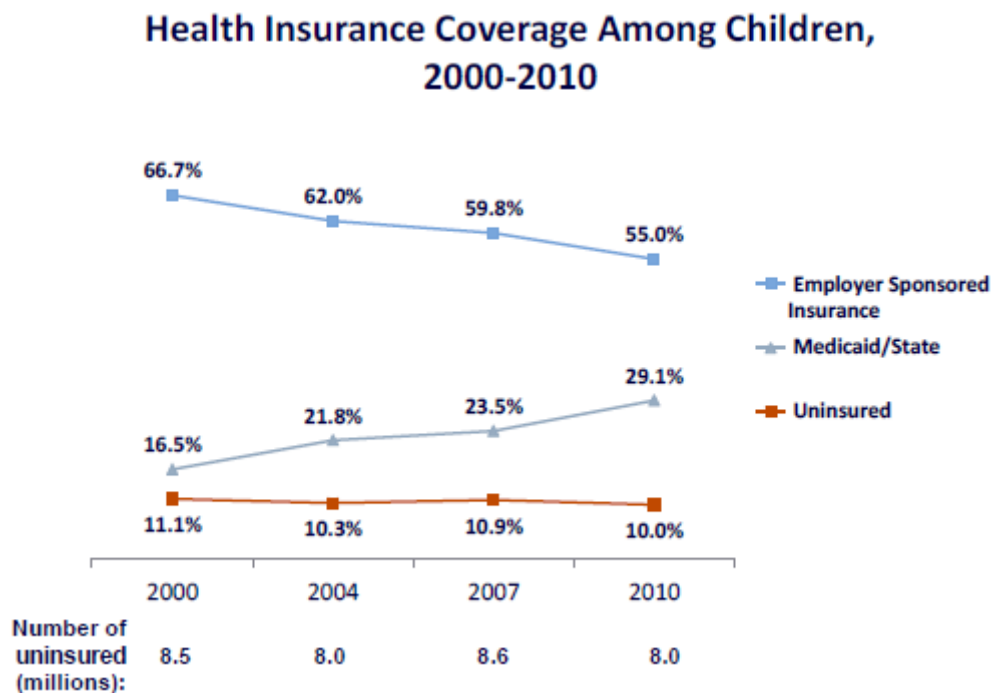
**Figure 5.4-1: Health Insurance Coverage among the Nonelderly 2000-2010**



SOURCE: Urban Institute, 2011. Based on data from 2001-2011 ASEC Supplement to the CPS.

Still while public coverage through Medicaid or CHIP filled a gap in coverage, it is necessary to understand that changes in health insurance coverage are largely influenced by the economic conditions, and this rising throughout the decade did not offset all of the loss in the private coverage. The Medicaid and CHIP partially offset the losses in private insurance coverage due to the increase on the enrollment of children (Holahan & Chen, 2011).

Figure 5.4-2: Health Insurance Coverage Among Children, 2000-2010

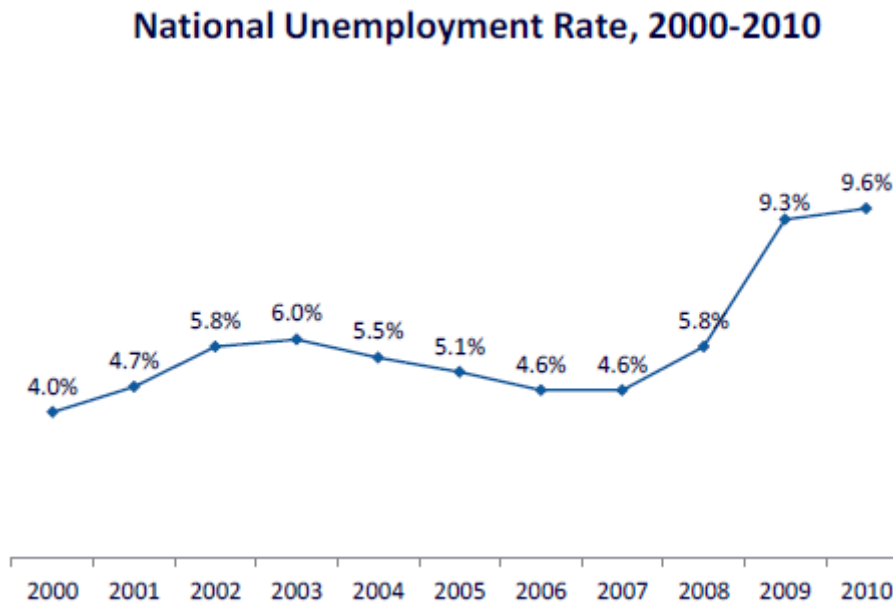


SOURCE: Urban Institute analysis for KCMU, 2011. Based on data from 2001-2011 ASEC Supplement to the CPS.

Despite the losses in private insurance coverage, between 2009 and 2010 the trend for the group of young adults (ages 19-25) was actually different from the other groups, who experienced a decline in their private coverage. There was an increase in private coverage from this group mainly because the ACA permitted them to stay on their parents' insurance coverage (Holahan & Chen, 2011).

Since the beginning of the financial crisis in 2007 the rate for employer insurance coverage decreased from 63.5 to 58.8 percent; Medicaid Coverage increased from 11.8 to 14.4 percent and the share of the adult population uninsured increased from 19.1 to 22 percent, an increase of 6.3 million. Almost all the increases in the number of uninsured adults were among those with incomes below the 200 percent of the Federal Poverty Level (FPL) (Holahan & Chen, 2011). The FPL is a simplified version of federal poverty thresholds issued by the HHS and used for administrative purposes, mainly the determination of financial eligibility for certain federal programs, like the Medicaid for example (U.S. Department of Health & Human Services, 2012). These results can be associated to the fact that unemployment has steadily increased along the decade as it is visible in the graphic below.

Figure 5.4-3: US Unemployment Rate, 2000-2010



SOURCE: Bureau of Labor Statistics: Current Population Survey: Labor Forces Statistics. U.S. Department of Labor.

Although the impact of the recession has been mitigated to some degree by Medicaid provisions of ACA, especially the expansion of its eligibility including all low income citizens at or below 133 percent of the FPL, Before this expansion takes effect in 2014, Medicaid does not provide medical assistance for all poor citizens (Holahan & Chen, 2011; Klees, Wolfe & Curtis, 2011). Dramatically none of the ACA reform laws subsidies are available to undocumented immigrants, and Medicaid covers legal immigrants only after they have resided in the US for at least five years which accordingly to Hall (2011) will constitute roughly a quarter of the remaining uninsured.

The ACA expansion of public and private insurance is monumental, but it will leave about 23 million residents uninsured, 8 percent of the total nonelderly population in the US. Still it is expected that the Medicaid enrollment will grow by 19.5 million people in 2014 (Hall, 2011; Klees, Wolfe & Curtis, 2011).

It is expected also, that those newly insured through the Medicaid expansion and exchanges will devote a greater proportion of their total health spending to physician and clinical service and prescription drugs, rather than hospital care (Klees, Wolfe & Curtis, 2011).

Medicaid is the largest source of funding for medical and health care related services in the US for low income citizens, and although the reform law's individual mandate to purchase insurance will only apply to people for whom decent insurance costs are less than 8 percent of income, insurance subsidies phase out at 400 percent FPL and many people near or

above that level will have to face insurance premiums much greater than 8 percent of income (Swartz, 2009; Klees, Wolfe & Curtis, 2011; Hall, 2011).

## 5.5 Wellness Programs

With the escalating costs of health care benefits given to employees by employers, an interest in reducing health care payments while at the same time improving the employees' health has arisen (Rothstein & Harrell, 2009a).

Historically, public health officials, health care providers, health insurers among other have used many techniques in order to encourage individuals to improve their own health, since there has been an increased awareness of the role of lifestyle in health risks. There has also been a growing need to increase personal responsibility regarding the utilization of health care and its outcomes. Recently, one specific mechanism for health improvement has gathered increasing attention: financial incentives (Madison, Volpp & Halpern, 2011; Rothstein & Harrell, 2009a).

Furthermore there is a common trend concerning recommendations of several health reforms that emphasize in policies that change behavioral factors that lead to chronic diseases. The ACA is no different and follows in these footsteps. It has provisions that regulate public and private insurance. For example, the ACA requires coverage of preventive care without patient cost sharing and it authorizes insurances, both private and public, to provide incentives for citizens that wish to participate in wellness programs (Mariner, 2012b). In fact, employers, in an effort to improve health, have been gradually turning to financial incentives, a tendency consistent with the growing international interest in health incentives and which the ACA seems to reinforce. In truth, despite promoting health incentive programs in a variety of contexts, which include the Medicaid Program and the market of individual insurance, the ACA regards the employers with a central role in the offering of incentives that promote healthy behaviors (Madison, Volpp & Halpern, 2011). In truth, the primary ethical justification for these incentives is beneficence, a statement of moral obligation to act for the benefit of other, in this case the health improvement of the employees (Rothstein & Harrell, 2009b).

But what is a Wellness program? A wellness program, according to Bard (2011), consists in an organized effort by employers to reduce costs by encouraging employees, who benefit from their health insurance, to adopt healthier lifestyles. They specifically address behaviors or inherited characteristics that put the employees at a greater risk of illness, and consequently increase absenteeism among workers (Bard, 2011).



In other words, wellness programs by being specifically address to individuals' behaviors, deal with personal responsibility.

For the aforementioned reason and by quoting Guttman and Ressler (2001) "appeals to personal responsibility in health campaigns require responsible application". Moreover they carry implications beyond the health context. As Guttman and Ressler (2001) argued, over the years responsibility has been a major notion in public discourse on autonomy, equity, and social regulation of behavior. In truth, personal responsibility can be seen as key concept in understanding how individuals evaluate, sanction, and try to control each other's conduct in a society (Guttman & Ressler, 2001).

The rewards given by Wellness programs must be available annually in order to ensure they are available commonly enough to motivate a change in behavior among all participants. Moreover they must be available to all individuals in a similar situation, i.e., programs must allow a waiver when it is inadvisable, medically speaking, for an individual to try to accomplish a standard, as well as when in order to satisfy a standard the medical conditions of an individual make it unreasonably difficult. The waiver for an alternative standard must be disclosed. Ultimately the rewards, for the satisfaction of the health status-related standards, may not exceed 30 percent of the coverage (including the contribution from both the employer and the employee). If deem appropriate, the Secretaries of Labor, Health and Human Services, as well as the Treasury have the authority, granted by the statute, to increase the ceiling to 50 percent (Madison, Volpp & Halpern, 2011; Bard, 2011).

Rothstein and Harrell (2009) argued that in a health care system where it is optional to have employer-sponsored group health coverage, offering benefits represents, for the employer, a combination of beneficence and income maximization. And the cost savings might improve the ability to pay the health plan, save money for the health care system in general and most important, improve the health outcomes for the individuals (Rothstein & Harrell, 2009b). Several employers in the US believe wellness programs save money in health costs, and, as an added bonus, raise productivity, since healthy employees are more productive. They try to create a culture of health (Bard, 2011).

There are several variations for the basic concept of a wellness program however the dividing point is between voluntary ones and mandatory ones. The first ones work by promoting healthier lifestyles to the employees while the mandatory programs require the participation of the employees, and may also demand them to achieve health-related goals in order to get any incentive (for example, the reduction in the price they have to pay for health insurance) (Bard, 2011).

However it is important to understand that the goal of wellness programs is to change certain behaviors or a limited set of personal traits. Traits like obesity and behaviors like smoking, and even though they are regarded as promoting good health there is the concern that they can reintroduce the risk classification that the ACA is trying to eliminate. Despite that, wellness programs under the ACA must be “reasonably designed to promote health or prevent disease” and cannot be a subterfuge for discriminating based on health status factor”. Yet the potential for discrimination has begun to raise concern in the US. Furthermore as Mariner (2012) noted, insurance is used for spreading and managing risk, it is not designed to improve the policyholder's physical or mental wellbeing. It has, however, an important role in shaping public attitudes regarding the responsibility for health risks (Mariner, 2012b; Madison, Volpp & Halpern, 2011).

Mariner (2012) also argues that insurance is poorly suited to improve health or manage behavioral risks to health and operates best as a mechanism for financing access to preventive care without cost-sharing. She considers the tools of insurance too crude to attribute to specific behaviors the health care costs of chronic conditions with complex causes. In truth wellness programs that reward good health or penalize unhealthy behaviors are likely to shape the perceptions of the public regarding the social worth of the individual and justify abusive practices, such as denying employment, on the pretext of improving public health. Wellness programs should be offered independently of insurance.

The ACA insurance provisions to promote health are divided in three different approaches (Mariner, 2012b):

1. Encouraging and funding government and community research, education, and projects to improve health and provide health promoting conditions;
2. Requiring coverage or preventive health services in public and private health insurance programs;
3. Authorizing both state Medicaid plans and private health insurance plans, including those sponsored by employers, to offer wellness programs.

The first two approaches do not raise any controversy but the third one, regarding the wellness programs, allows employers and insurers to hold nonparticipating or unsuccessful plan enrollees responsible for a larger share of costs (Mariner, 2012b). It allows costs to be shifted to those who are responsible for them, for example, smokers could be required to pay higher premiums than non-smokers (Madison, Volpp & Halpern, 2011).

The primary interest of the incentives given by wellness programs should be to improve health and not merely to redistribute costs. Furthermore, health is frequently viewed as a

personal matter, privacy and confidentiality is appreciated which can lead for some employees to be unwilling to disclose personal health information to their employer-sponsored health plan. In addition no individual is exactly the same, many factors affect an individual ability to respond to a health incentive, and even their preferences for unhealthy behaviors differ. Historical, cultural and environmental influences shape the individual and their preferences help to determine the costs of sacrificing unhealthy behaviors. Some are more averse to effort and some may face higher costs in exercising willpower (Madison, Volpp & Halpern, 2011).

These programs introduce a contradiction in the ACA. Insurance provisions generally eliminate risk segmentation within insurance pools, for instance, by requiring guaranteed issue and coverage of preexisting conditions. The wellness program provisions reintroduce some risk segmentation into the plan's pool of enrollees. In other words despite the ACA provision that prohibits group health insurance plans from discriminating with respect to premiums or eligibility or benefits on the basis of "health factors", it allows plans to offer premium discounts or rebates or modify cost-sharing for "adherence to programs of health promotion and disease prevention" (Mariner, 2012b). Employer-sponsored health plans should strive to provide a fair and equal opportunity to change behavior (Madison, Volpp & Halpern, 2011).

In general, wellness programs are permitted to include smoking cessation, weight management, physical fitness, nutrition, health disease prevention, healthy lifestyle support, and diabetes prevention. Health insurers and group health plans are to report annually the results of the wellness programs, as well as other quality measures, such as medication and care compliance initiatives, and activities to prevent hospital readmission, improve patient safety, and reduce medical errors (Mariner, 2012b). In addition, if a program meets a series of requirements, the ACA allows rewards based on satisfaction of health status factor-related standards. The rewards vary from discounts or rebates of a premium or contribution, a waiver of all or part of a cost sharing mechanism, the absence of a surcharge or the value of a benefit that would otherwise not be provided under the plan. The ACA also permits premium discounts, rebates, or other rewards not based on the accomplishment of health status factor-related standards if the programs are accessible to all similarly situated individuals (Madison, Volpp & Halpern, 2011).

Concerning the public insurance, in particularly state Medicaid programs, the ACA authorizes federal grants to provide incentives to Medicaid beneficiaries who successfully participate in wellness programs and demonstrate changes in health risk and outcome, including the

adoption and maintenance of health behaviors by meeting specific targets. The eligible programs are those where there is success in one or more of the following (Mariner, 2012b):

1. Ceasing use of tobacco;
2. Controlling or reducing weight;
3. Lowering cholesterol;
4. Lowering blood pressure;
5. Avoiding the onset of diabetes or, in the case of a diabetic, improving the management of that condition.

Consequently it seems important to know whether policies like wellness programs can either improve health or control cost. In general wellness programs are expected to improve health and save money. Furthermore disease management or wellness programs are becoming an ever more popular addition to employer cost control methods. It is their hope that these types of programs can reduce the cost of health insurance, decrease absenteeism, and improve employee productivity (Mariner, 2012b).

It is still too early to make a fair assessment of the outcomes of wellness programs but recent evidence suggests that cost savings may depend on the how intensive a program is and on how substantial the incentives are. In truth, the great advantage of wellness programs is that it highlights the value of preventive measures to improve health (Mariner, 2012b).

Yet, as Steinbrook (2006) argued in his article, there are two questions we should pose regarding wellness programs (Steinbrook, 2006):

1. Which measures to promote a responsible behavior make a difference and which of them are primarily coercive and potentially counterproductive?
2. Which measures may actually improve health and save money, and which simply shift costs from government, private insurers and employers to individuals?

Bearing these questions in mind, especially the last one, it is important to know that the cost of care in health is determined more by the health care providers than by the individuals and if a government wants to reduce the costs, it would be more effective to regulate those who set the fees, instead of spreading the costs back onto those who use the services. In truth, a community based or a public health approach should recognize that promoting health is a social responsibility to make a healthy life attainable instead of enforcing an individual duty to stay healthy and save money (as the wellness programs seems to be doing in the US health system). Still incentives given by wellness programs can induce a healthier behavior and as Mariner (2012) refers, the most effective way to improve the population's health are likely to

lie in improving the social determinants of health (income, education, employment, housing, genetics, the environment, and even political inequality) (Mariner, 2012b).

However Mariner (2012) also pointed out that the incentives permitted for wellness programs are likely to be too crude to significantly improve the population's health or save money, and they pose an unnecessary threat to the underlying goals of the ACA, i.e., they do not belong in an insurance system that avoids risk classification.

## **5.6 The ACA and the Massachusetts Health Reform Law**

It is still too early to accurately predict the impact of the ACA in the American health system but in April 2006, the state of Massachusetts enacted a comprehensive health reform law intended to provide affordable health insurance to most of its uninsured residents. The Massachusetts Law was used as a model for the ACA, because it combined expanded Medicaid eligibility, a new combined small group and individual private health insurance market, and a requirement that individuals purchase health insurance if affordable, with subsidized premiums for low-income residents, with financing from cigarette taxes, small fees from employers who do not offer health insurance, and Federal Medicaid funding (Mariner, 2007).

It is easy to see that much of the ACA is modeled after the Massachusetts reform law, so it seems plausible to use the outcomes of the Massachusetts reform as a prediction of what it is to come with the ACA.

One of the goals of the Massachusetts reform law was to spread the financial risk of insuring the individual and small-group populations over a large pool of insured and help make individual insurance more affordable. With 6.5 million residents the state of Massachusetts achieved nearly universal health insurance coverage. In 2011, five years after the enactment of the law, the goal referred above has been effectively achieved. An estimated 98.1 percent of Massachusetts residents have health insurance coverage, including an astonishing 99.8 percent of children. These gains in health coverage, most of which occurred during the first two years of health reform implementation, have been maintained despite the effects of the US severe and sustained economic downturn (Raymond, 2011).

According to Raymond (2011) the expanded coverage in Massachusetts has been accompanied by an improved access to care, especially among low-income adults, with significant increases in physician office visits and the use of preventive care, and in the percentage of adults with a usual source of care. Even so, only one in five non-elderly adults

have reported problems finding a physician that would see them. It is important to note that almost 78 percent of insured Massachusetts residents receive their coverage through an employer, and although the number of enrollees with employer based coverage has fallen since the beginning of this economic recession, employer participation in offering health insurance has risen under the health reform (Raymond, 2011).

Furthermore, 77 percent of Massachusetts employers with three or more employees offered health insurance coverage to their employees in the year of 2010. Seven percent points above the number of 2005. Nationwide the percentage of employers offering health coverage to their workers it is around 69 percent (Raymond, 2011).

Regarding the non-group coverage, in 2011, Massachusetts established a fixed enrollment period for individuals to sign-up, with some exceptions. Previously, eligible individuals could enroll at any given time during the year. Some insurers raised concerns with the legislature since, despite the individual mandate, people were buying insurance only when they needed expensive medical care and then dropping coverage as soon as the insurer paid the bills (Raymond, 2011).

Corollary the public support for the health reform of Massachusetts has remained stable since the law was enacted. Around two-thirds of the adult residents of the state pronounced their support for the health reform. Moreover the stakeholders and interest groups that helped forge an agreement on the 2006 law, including political leaders, consumer advocates, business groups, labor unions, hospitals, physicians, and health insurers, have remained engaged and largely supportive (Raymond, 2011).

Nevertheless, the state of Massachusetts has been consistently among the states with the highest per capita health spending. Attention has started to shift to cost-containment. According to Zimmerman and Goldberg (2012) when Massachusetts passed their health insurance reform in 2006 a crucial piece was left out from the landmark legislation – how to control rising medical costs (Raymond, 2011; Zimmerman & Goldberg, 2012).

Prices paid to hospitals and physicians vary significantly, furthermore the difference in those prices correlate with size and market leverage and not with the quality of care or the complexity of cases. A special payment reform commission that included representatives of the private and the public sector have unanimously recommended that Massachusetts move away from the typical fee-for-service payments and make global payments based on quality, outcomes, and efficiency as the predominant form of provider payment within five years (Raymond, 2011).

In 2012, state lawmakers, unveiled an ambitious new proposal to control rising medical costs, mainly new ways to pay physicians and hospitals, a specific cap on health care spending tethered to economic growth and a tax on the state's most expensive hospitals if they can justify their prices. Professor Jonathan Gruber one of the architects of the state of Massachusetts health law of 2006 and an advisor to President Barack Obama on the national ACA calls this proposal "aggressive, broad and visionary" (Zimmerman & Goldberg, 2012).

Below are some details regarding the Health Care Quality Improvement and Cost Reduction Act of 2012 for the state of Massachusetts referred by Zimmerman and Goldberg (2012):

1. **Oversight:** A new, quasi-governmental agency called the Division of Health Care Cost and Quality would oversee the transition to the new payment and delivery system with a board including consumer, government and industry representatives.
2. **Cost-Cutting:** To curb the increase in medical spending, the plan establishes a cap for health-care spending linked to the local economy, the Gross State Product, minus one-half a percent.
3. **Leveling The Field:** The state could impose a 10 percent "luxury tax" on pricey hospitals that charge more than 20 percent of the state median price for a given service without being able to justify that higher price. Hospitals would pay this penalty into a "distressed hospital" fund for institutions that serve a high proportion of poor and vulnerable patients.
4. **Accountable Care Organizations (ACO)** would take on greater prominence, patients would have the right to appeal decisions made by their ACO doctors, and have the right to a second opinion.
5. **Shifting Payments:** The state's medical establishment would continue its shift toward global payments and away from fee-for-service systems. The measure would "transition the industry to adopt alternative payment methodologies such as global payments and bundled payments for acute and chronic conditions."
6. **Technology:** Electronic health records would be required for all providers by 2017.
7. **Greater transparency** would be attained through detailed pricing available to consumers on the internet, as well as greater disclosure of OOP costs to patients up front.
8. **Streamlining Care:** The measure stresses greater coordination of care through primary care, and the establishment of "patient-centered medical homes" so that patients could have a single point of coordination for all types of care.

9. **MedMal:** New rules on medical malpractice would create a 180-day cooling off period while both side try to negotiate a settlement. Also, the measure would allow providers to freely offer an apology to a patient.
10. **Tiering:** Under a provision called “smart tiering” patients might pay more for more expensive services.
11. **Upping The Rates:** The bill would make several changes to Medicaid, including increasing MassHealth (Massachusetts Medicaid and CHIP program combined together) rates paid to providers.
12. **Training:** Funding for workforce training and development are included in the measure and a provision would forgive loans to primary care doctors who practice in rural or underserved areas.

It is still too early to make an accurately prevision of the consequences of these measures. Moreover the Massachusetts legislature is due to pass a bill to reform payment structure by the end of July 2012, but many of the bills in the legislature do not include the more aggressive approaches. There is the prediction that the outcome of the law will not be enough to control the costs in health care.

Nevertheless, although Massachusetts health reform clearly provided a model and framework for the ACA there are significant differences in the two approaches. As Raymond (2011) mentioned the differences need to be resolved. For example, the ACA will affect eligibility, enrollment, and Federal funding for the MassHealth and Commonwealth Care (Massachusetts Health insurance) programs, as well as employer obligations and the responsibilities of the Connector in its role as an insurance exchange under the ACA. However the ACA also provides an opportunity to the state of Massachusetts to advance key initiatives such as integrating care for the dual eligible (Medicare and Medicaid) populations, and to reconsider the way the state structured its public coverage programs (Raymond, 2011).

Despite the similarities between the two reforms only now is the reform of Massachusetts starting to focus in cost-containment measures and as it was already referred although the ACA does not directly regulate the cost of care, many of its provisions are intended to develop new ways to slow down public and private spending for health care, especially regarding chronic diseases, which are reported to account for the majority of health care costs (Mariner, 2012b).



## 6. ACA Lessons to the Portuguese Health System Management Framework

### 6.1 Expenditure and Resource Management

*“What is best for health and health care can only be answered on a country-by-country basis considering cultural values, national socio-economic reality and the alternative uses for money within and outside the health sector”* Bicknell, W. J. (2011)

Mushlin and Ghomrawi (2010) wrote, regarding the ACA, that if left to measures in the proposed reform legislation, cost-containment will be driven primarily by marketplace incentives, programmatic initiatives, and organizational changes that would partially offset the cost of expanding coverage (Mushlin & Ghomrawi, 2010). The authors had the ACA in mind, but part of what they have written can be applied to the Portuguese reality. Cost-containment will be driven by marketplace incentives.

Faria (2010) considers pharmaceutical expenditure as a major health budget problem considering the most needed health sustainability in Portugal (Faria, 2010).

According to the OECD Health Data (2011) the rise in pharmaceutical spending has been one of the factors behind the increase in total health spending in many OECD countries. In the year 2008 Portugal spending on pharmaceuticals accounted for 20.6 percent of total health spending. The average in the OECD was 16.9 percent (OECD, 2011).

Furthermore as Kenneally and Walshe (2012) referred the scale and growth of pharmaceutical expenditure challenge the ongoing sustainability of some national health systems and the key values of universal coverage, solidarity in financing, equity of access, and the provision of high-quality health care that underlie them (Kenneally & Walshe, 2012).

Portugal is no different especially with a 20.6 percent of spending on pharmaceuticals (on total health spending) therefore some of the new measures proposed for the Portuguese health system are focused in the pharmaceutical sector.

Unfortunately few measures are universally effective – generic substitution combined with reference pricing maybe an exception. According to Kenneally and Walshe (2012), some as positive lists, prescribing budgets, and reference pricing were effective in some countries but only in the short term. Furthermore volume or profit controls, rebates or paybacks, can achieve short-term savings but by inhibiting access to treatments for patients who need them and discouraging health care innovation they may negatively impact health outcomes, medical innovation, and long-term health costs (Kenneally & Walshe, 2012).

In the US the Medicare Part D was a Federal program made to subsidize the costs of prescription drugs for its beneficiaries and may be a useful international reference for pharmaceutical cost-containment policies. The program was intended to lower cost, increase efficiency, and broaden access to medicines but it may have resulted in higher prescription drug prices, large coverage gaps, higher co-payments for brand names and significant co-payment premiums for various patient cohorts (Kenneally & Walshe, 2012; Klees, Wolfe & Curtis, 2011).

Even if we use Medicare Part D as a reference for pharmaceutical cost-containment policies it is still too early to establish the consequence in the long term for the measures applied in the Portuguese health system.

Despite the pharmaceutical spending assuming a major role in the total health expenditures there is the need to look to the bigger picture. In the current environment, the ever-increasing cost of health care is overshadowing all other issues as the leading concern in determining the future of the health care system not just in Portugal but also in the US. With ACA potentially insuring 32 million more American citizens there is the need, not only, to bend the cost curve but also decrease the current cost of care which totals about \$2.6 trillion, almost 18 percent of GDP (Weinberger, 2011; Mariner, 2012b).

It is a widespread recognition that the health care system in the US, wastes a significant amount of resources on unnecessary services, both administrative and medical and that most economic incentives are far too crude to shape individual choices into the most efficient use of resources (Mariner, 2007). We can easily assume that this is a common problem in all countries.

In the US attempts to solve the problem are made through legislating reductions in Medicare and Medicaid spending however according to Weinberger (2011) they do not address the real problem since they are focused on reducing reimbursement for care and not in decreasing the actual cost of care (Weinberger, 2011).

Furthermore there is a general agreement that waste in the health care system represents a significant component of the high cost of health care not only in the US but also in Portugal. Weinberger (2011) mentioned, regarding the US health system, that estimates often suggest that approximately 30 percent of health care costs, or more than \$700 billion per year, is wasted. He said that it could be potentially avoidable and it would not negatively affect the quality of care if eliminated. As examples he cites overuse and misuse of diagnostic testing, avoidable hospitalization and rehospitalization and overuse of emergency department services (Weinberger, 2011).

Reich (2011) refers to a problem arising in Japan, where patients have certain expectations regarding their physicians. Expectations of what they are entitled to and what should be the physicians' behavior toward them. That combined with poor differentiation in service provision and misdistribution between specialties, have created bottlenecks in major medical centers, especially emergency care. Reich (2011) advises that because patients' expectations have changed, the roles of primary care physicians and specialists and the balance between them need to be adjusted (Reich, 2011).

Portugal also has similar problems to the examples given above, so for the aforementioned reasons the Portuguese Government is implementing measures to reinforce primary care services to further reduce unnecessary visits to specialists and emergencies and to improve care coordination, to move some hospital outpatient services to primary care units and increase moderating fees in certain services while ensuring that primary care moderating fees are lower than those for outpatient specialist care visits and lower than emergency visits (European Commission, 2011).

Moreover in Portugal, especially in the public sector, the purchase decision is directly related to clinical decisions; the physicians possess therapeutic freedom in the choice of care. Thus far, the pattern of increasing health care related costs has been closely associated with physicians' freedom of choice. Currently, Portuguese physicians benefit from immense freedom in the decision-making process when regarding health care assistance. This scenario is slowly changing due to cost-containment and it is predictable that physicians will gradually lose power over the purchase decision (Faria, 2010).

Besides in the US, the late 1980' and early 1990' saw a paradigm shift when physicians became providers or vendors and patients became consumers or covered lives with responsibilities as well as rights (Mariner, 2007). Health care started to be considered more like a commercial consumer product than an entitlement. There was a change in attitude. Portugal may be experiencing this phenomenon right now.

Furthermore the cost of care is determined more by health care providers than by individuals (Mariner, 2012b).

In addition, it is unusual for resident physicians to have information about the costs of the care they are providing, and they are rarely taught about the cost implications of their care, and now that cost control in health care has reached a critical level an essential measure to apply both in Portugal and the US would be a regulatory clout that would change the culture of the training environment with regard to health care costs (Weinberger, 2011).

As Faria and Lupi (2009) mentioned the administration of the resources exceeds the management of patients' problems, seen through individual perspective, because it involves strategically weighing the needs of patients and maintain the appropriate health services (Faria & Lupi, 2009).

Nevertheless, in 2001, Campos remarked, regarding the costs in health, that one can be tempted to consider that the waste in the sector is due to poor financial management and that everything would be resolved if there was more discipline. Another temptation is to assume that the patient is the source of all expenses and that he should be brought to a stronger participation with the public health burden through the proportion of their income. None of these pathways, when separately followed is correct, but none of them is entirely incorrect (Campos, 2001). This is still true in the present day.

Another paradigm we should bear in mind is that unlike markets for other products an increased supply and competition in health care have rarely led to lower prices for medical care. New medical technologies often are more expensive than the existing technologies, and many are used in addition to, rather than instead of, earlier technology (Mariner, 2007) – once again the measure to improve physicians' training regarding health care costs seems plausible.

Also the market is not a redistributive device because it necessarily allocates goods according to the ability to pay. They simply cannot solve the most pressing problem in health care today. Thus health care is simply unaffordable for millions of American citizens (Mariner, 2007).

## **6.2 Insurance Exchanges**

As it was already mentioned, the development of insurance in the US included elements that largely determined the shape of health insurance today. Elements like tax treatment, placing the locus of the insurance pool in employers, and its focus on hospital based care. This is a large contrast when comparing with national insurance programs in Western European countries, who took root before the private insurance industry had much presence in health and which left considerable room for government supervision or control without having to battle large entrenched interests. Thence the insurance industry plays a decisive role in American health policy, unlike its more subordinate, functional position within national health systems elsewhere (Mariner, 2007).

Concerning Portugal, the activity of the health insurance market plays a major role in financing the health system, despite being voluntary and being inserted in a context of free market legislation common to the general insurance sector. Furthermore Portuguese insurers offer limited products in terms of coverage and benefits, seeing themselves as complementary and supplementary to the NHS (Ministério da Saúde. CSFSNS, 2007).

In 2007, Campos considered the insurance market as a market with great capacity to adapt to new contexts, especially with the entry of large foreign groups in the insurance sector (Ministério da Saúde. CSFSNS, 2007).

The ACA changes how the health insurance works and makes it affordable; it also includes measures to improve the quality of medical care and control its costs. It does not substantially alter, however, how medical care is organized and it may not change the long-term trajectory of health spending (Starr, 2011). In addition it allows the creation of Exchanges. As it was already mentioned the Exchanges represent insurance marketplaces through which individuals, families and small employers can competitively shop for new insurance products and obtain federal tax credits and subsidies to do so.

This is a major breakthrough in the health insurance market in the US. The possibility of choosing a specific type of Insurance with the outlined benefits and prices would be a welcome measure in the Portuguese health system especially with the known capacity the Portuguese insurance market has to adapt to new contexts.

To create an Exchange were Portuguese citizens could choose which insurance to use to complement benefits not covered by the NHS would be a fresh measure and possibly a welcome one.

In Portugal, 25 percent of the population has a healthcare subsystem and around 20 percent a VHI, some individuals even have both. And it seems these numbers are gradually rising (Barros, Machado & Simões, 2011). Since insurance works as supplementary and complementary to the Portuguese NHS, a national Exchange could gather in one place all the insurances. This insurance market would have all the benefits and premiums discriminated, allowing the individuals to choose which insurance would benefit them the most.

It would be easier for the individual to browse among the several insurance available. With it the individual could choose an insurance that would give him a service not provided by the Portuguese NHS. This can assume a key importance in the present times since the new measures being applied in our health system are removing certain provisions that used to be easily accessible by the NHS.

The national Exchange in Portugal would be available to all the population and its main purpose would be to facilitate the selection of insurance by an individual. By browsing this market the individual could select an insurance better suited to his needs.

This national Exchange would not have a major impact in cost-containment in the Portuguese health system and its key advantage would be more in logistics. The individuals would be the great beneficiaries of this measure since they would have more information regarding the possibilities of acquiring a VHI, and how different insurances could have different impacts in their finances.

Concerning low-income individuals it is harder for them to acquire a VHI; still this national Exchange would give them the opportunity to get to know which insurance would be in their financial reach and which would be too expensive.

### **6.3 Wellness Programs**

In general, wellness programs are permitted to include smoking cessation, weight management, physical fitness, nutrition, health disease prevention, healthy lifestyle support, and diabetes prevention. The unfortunate truth is benefits that ensue from wellness programs, in a cost-benefit equation, do not translate, in any direct way, into real money. Furthermore the benefits raise the life-time costs of medical care. Thence, the justification for prevention (present in the nature of wellness programs) is primarily humanitarian, life-saving and life-enhancing. Though often claimed to be cost-saving, the justification for the use of prevention is not and can never be cost-saving (Mariner, 2012b; Bicknell 2011). However a failure to adopt healthy behaviors can greatly erode public health while, at the same time, increase health care costs (Madison, Volpp & Halpern, 2011).

The role of preventive care is, in its essence, to improve health, and not to save money. Despite the ACA promoting prevention and subsequently encouraging the use of wellness programs that focus on the public model of identifying and minimizing risk it also links health promotion to cost savings in ways that may be in the long run, both ineffective and counterproductive. By framing health as a personal responsibility, the overall goal of universal access to health care the ACA tries to achieve becomes inconsistent (Mariner, 2012b; Bard, 2011).

Furthermore the support of the ACA to employer incentive programs (which assume a central role in the statute) generates three controversies: the effectiveness of the incentive programs in improving health, independently of the sponsor; the fact that it may be inappropriate for

employers to influence in a major degree the health of their employees and finally the financial incentives of the program may be viewed as coercive or as potential tools for discrimination (Madison, Volpp & Halpern, 2011).

So, while implementing health care measures based on personal responsibility may seem intuitively attractive, designing and implementing these in health insurances may be complicated. Wellness programs should be rigorously evaluated in a controlled trial by independent groups and in case of unanticipated negative side effects or if they do not improve health or save money, they should be revised or discarded (Steinbrook, 2006).

As it was already mentioned health insurers and group health plans need to report the results of wellness programs, quality measures, compliance initiatives, activities to prevent hospital readmission, improve patient safety and reduce medical errors annually (Mariner, 2012b), these types of reports could be used to a larger extent on the Portuguese NHS and in a certain way they are being implemented by the new measures of the Government; still they do not seem very patient oriented.

The wellness programs encourage the public and private insurance companies to incite their beneficiaries to conform to behaviors that are believed to save money by preventing chronic diseases. The problem resides in the fact that it is unclear whether wellness programs can achieve those goals or not, and mainly because the programs are highly variable in producing behavioral change and because substantial savings are unlikely to occur in the long-term. This is particularly important when there are so many insurers in the market and when individuals change employers and consequently insurance companies, furthermore when citizens reach 65 years they go to Medicare, so no singular insurer gets benefits in the long-term (Mariner, 2012b).

Insurance reflects what society deems acceptable, which risk are we willingly to share and which risks should remain the sole responsibility of the individual, furthermore, insurance shapes public perceptions of risk. It was already stressed many times over that the overall goal of the ACA is to enable access care to everyone without regard why care is needed. This is done by eliminating risk classifications based on health status. The wellness programs, however, reintroduces risk rating back to the insurance pool, but only for certain conditions and once again health status may become a socially acceptable basis for discrimination (Mariner, 2012b).

A key consideration for wellness programs to work is voluntariness. Bearing a practical and an ethical perspective, it makes sense for participants voluntarily undertake the incentives on changes in behavior, rather than on outcomes whose achievement may be out of one's

control. However for low income individuals, if the only way to obtain affordable insurance is to meet the targets wellness programs propose, voluntariness can become questionable and the programs may feel like coercion to obtain affordable insurance. They face increased pressure to participate and obtain the financial reward (Madison, Volpp & Halpern, 2011; Rothstein & Harrell, 2009b).

Despite being prone to risk classification, the wellness programs seem to have potential and with an increase of the Portuguese NHS moderating fees implementing these types of programs in our health system can promote healthier behaviors and consequently a lower use of unnecessary health care. The advantage of applying the wellness programs in the Portuguese health system is a simple one. We already possess universal health care coverage so the possibility for health discrimination is small (still it may prove impossible to eliminate discrimination or inequality in the health sector). In addition, since the universal coverage comprises of a pool with individuals of all ages and the NHS function as a huge insurance paid (in its majority) by the state, wellness programs could be used as a way of the government saving money without making several cuts in the provision of health care. Furthermore the wellness programs benefits could comprise of credits or vouchers, allowing the individuals to accumulate them and use them to acquire other health care without having to pay the totality of a moderating fee.

Furthermore financial incentives provided by wellness programs can be the “extra push” affected individuals, need and want in order to pursue their self-defined goals. It may be possible, that in some cases, financial incentives remove financial barriers allowing individuals to achieve healthier behaviors (Madison, Volpp & Halpern, 2011).

Madison, Volpp and Halpern (2011) argued that, rather than ask “Do these programs work?” the question we should ask ourselves is “Which programs designs are most effective in improving health?” (Madison, Volpp & Halpern, 2011).

## 7. Conclusion

*“Finally, there is the problem of choosing between incremental reform and revolutionary change”* (Mariner, 2007)

The ACA presents itself as a breakthrough in the American health system. With the minimum coverage requirement the health insurance sector in the US moves away from a personal responsibility model to a much closer model of social insurance (Mariner, 2012b).



For all that was mentioned during this work, the ACA will significantly change the way health insurance is seen by American citizens. Universal health coverage will become a step closer and health expenditure may indeed decrease.

With removal of risk classification, people with a history of health problems are allowed to finally benefit from a health insurance without paying huge premiums. And with the individual mandate the pool of insured citizens grew permitting lower premiums and a better cost-sharing.

Also innovative tools like wellness programs and insurance exchanges may start a new trend that can alter the pathway health systems all over the world have been following. And with the introduction of competitive market reforms in European countries with social insurance systems, the culture of solidarity common to those countries may be diluting so the need for change seems at hand (Mariner, 2012b).

However, as Mariner (2012) pointed out, it is difficult to engage in anything that feels like a deprivation today if a benefit is far in the future, as is the case with most wellness programs, and if the problem is the cost of care, better information is needed about the relative cost of different health risks (Mariner, 2012b). This is exactly what it is happening in the Portuguese health system with the implementation of new measures. By taking what the citizens have taken for granted all their lives without any benefit in the short-term.

Furthermore most of the health measures being implemented in Portugal seem more oriented to cost-containment without regard for the impact they will have in the common citizen. The creation of a national Exchange may prove to be a measure “for” the citizens instead of a measure “against” them. In addition the creation of wellness programs in Portugal would probably give the individuals a chance of “fighting” the increase in OOP payments.

Regarding the US, in all due fairness the better solution for their health system would be a federal one, more specifically a universal social insurance program, Medicare for all, because it would be the fairest approach covering everyone, and most efficient, avoiding unnecessary administrative complexity and cost that private insurance entails (Mariner, 2007). In 2007 Mariner said that the US would probably not go there until it had exhausted every other more expensive and complicated option. It did not. So the ACA came to be, and with all its flaws it is still a very good bargain for the majority of American citizens, but as it is well known almost every single stakeholder can find something to dislike in any proposal for a national health insurance, so it is virtually impossible to achieve unity on any single approach (Mariner, 2007).

Concerning the Portuguese health system and especially the new measures being implemented I think it is important to quote Campos (2007) concerning organizational measures (Ministério da Saúde. CSFSNS, 2007):

- a. More and better information on the economic and financial performance of a system are a prerequisite for selecting measures with an impact on efficiency and cost control;
- b. Coercive measures on health management entities reduce responsibility, discourages the manager, increases waste, impair the performance and do not reduce spending.

It is still too early to make predict what is going to happen in the long run to the health systems of Portugal and the US, but maybe, we can learn something from each other and improve ourselves in the process.

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## 9. Annexes

**Table 10-1: The health care system: historical background and recent reform trends – timeline**

<b>1901</b>	The first act of public health legislation was published, whereby a network of medical officers responsible for public health was created. It followed the international trend set by several institutions, which tried to develop the basis of the public health movement. This is thought to be the root of “modern sanitarianism” (Ricardo Jorge reform).
<b>1940</b>	The first (specific) Health Department within the Ministry of Internal Affairs was established.
<b>1944</b>	The Social Services Statute was published, comprising a “minimum state intervention” principle in the social arena.
<b>1945</b>	Public maternity and child welfare services were established. Vertically organized national institutes and programs for TB, leprosy and mental health, which were already operating, were also legally established.
<b>1946</b>	<p>The law was passed that laid the groundwork for hospital organization and the promotion of new hospital buildings, financed by government funds, but run by <i>Misericórdias</i>. Hospital regionalization was initiated.</p> <p>Hospitals were to reorganize into three levels, namely municipality, district and region, ensuring technical cooperation among them.</p> <p>A mandatory social health insurance system for a limited number of professions was created: the <i>Caixas de Previdência</i>.</p>
<b>1958</b>	The Ministry of Health and Assistance was created.
<b>1963</b>	Statute of Health and Assistance, according to which the state is obliged to co-finance the installation and functioning of health facilities.
<b>1968</b>	The Hospitals Regulatory Act defined the nature and attributions of hospital care.
<b>1971</b>	The state was acknowledged to be responsible for health policy and implementation, for the integration of health activities, and for investment in disease prevention and health promotion. Citizens’ right to health was also recognized. Primary care centers were created.
<b>1974</b>	The democratic revolution occurred on 25 April, which ended a long period of right-wing political dictatorship. As a result, health services administration was taken from private holders that had been financed mainly by public funds, aiming to give the whole population access to health care, irrespective of ability to pay.
<b>1976</b>	The Portuguese Constitution was approved, which embodied citizens’ right to health care. It recognizes citizens’ right to health care by “the creation of a universal, free-of-charge National Health System”.
<b>1979</b>	The NHS Law created a universal health system, free at the point of use.
<b>1982</b>	The career of general practitioners (GPs)/family doctors was created.
<b>1988</b>	The Law on Hospital Management established guiding principles for NHS hospitals, including

	entrepreneurial management, decentralization of decision-making through intermediate responsibility centers and nomination of management boards by the government.
1989	The first pricing list based on DRGs was issued for third-party payers with respect to NHS hospital inpatient use by their beneficiaries. The Portuguese Constitution was reviewed, and now states that the “National Health Service is universal and tends to be free of charge, taking into account citizens’ social and economic conditions”.
1990	<p>The Law on the Fundamental Principles of Health introduced new principles for the organization and functioning of the health system. Inter alia, an explicit role was assigned to the private profit-making and non-profit-making sectors through contracting with the NHS; the system’s operation and management was decentralized to the regional level and user charges were introduced for ambulatory services.</p> <p>Private practice was allowed in public hospitals, under certain conditions related to the seniority and position of physicians as well as to the status of exclusive employment in the NHS. Private financing of health care was allowed, and incentives for private health insurance were given. The possibility of creating an alternative health insurance system was also approved.</p>
1993	<p>The Statute of the NHS was published in order to accommodate the changes introduced by the Law of Fundamental Principles of Health in 1990, namely the decentralization of the health system, the integration of primary care centers and hospitals in health units and the contracting out of NHS services.</p> <p>The new internal organization of the Ministry of Health was published. A Decree on the statutory regulation of private health entities was issued in order to ensure the accomplishment of quality standards. Five RHAs (<i>Administração Regional de Saúde</i>) were established.</p>
1995	The first attempt at putting an NHS hospital under the management control of a private consortium was initiated with the launch of a public bid for proposals according to a set of predefined terms.
1997	Contracting agencies (initially named accompanying agencies) were created – one in each RHA – with the overall aim of providing the basis for the payment and provider split within the NHS. The contracting agencies should also promote means of citizens’ participation in health decision-making.
1998	<p>An experimental payment system for GPs working at primary care centers was introduced. The intention was to pay according to capitation and performance, instead of the traditional payment by fixed salary. Enrolment in this experimental system was voluntary.</p> <p>The National List of Health Equipment was published for the first time. A law on the principles of mental health policy was published, whereby community care is given priority over institutional care under different arrangements. The law also regulated the compulsory inpatient status of individuals with mental illness.</p>
1999	The National Health Strategy and goals for the period 1998–2002, involving a broad range of social partners, was published as a revised version of an internal document issued in 1998. Legislation was passed creating local health systems and reforming primary care centers. Local health systems were integrated into frameworks for hospitals, primary care centers and other health care provider entities.

	<p>Primary health care reform was based on financially autonomous primary care centers, with networks of primary health care teams. This legislation was not implemented.</p> <p>The Local Health Unit of <i>Matosinhos</i> became the first example of effective integration of local hospitals and related primary care centers into a unique provider entity. A law was approved in Parliament to fund a special program to reduce waiting lists for surgical procedures at NHS hospitals. The contracting out of non-NHS entities was allowed only after internal capacity was fully used. Responsibility Centers in hospitals were set up as a means of establishing intermediate management levels and promoting decentralization of authority and of responsibility, in order to achieve higher levels of efficiency in the NHS.</p>
<b>2000</b>	The use of an NHS Identity Card became mandatory.
<b>2001</b>	Regulations for the licensing and evaluation of private clinics and dentists' private practices were published.
<b>2002</b>	<p>A framework for the implementation of PPPs for the building, maintenance and operation of health facilities was created, along with the identification of the basic principles and instruments. A new law on the management of hospitals was issued to enable the changeover of some institutions into public enterprises.</p> <p>A total of 34 hospitals, corresponding to approximately 40% of all NHS hospitals, were transformed into public enterprises.</p> <p>A Decree established NHS drugs prescription using the common international denomination (International Nonproprietary Name, INN) as obligatory, as well as the conditions under which prescribed brands can be substituted by generics when dispensing. Reference prices for pharmaceuticals were introduced to cap state co-payment levels.</p>
<b>2003</b>	The Health Regulatory Agency (ERS) was created to ensure that citizens have access to health care and to guarantee competition among health care providers.
<b>2004</b>	The National Health Plan for 2004–2010 was approved.
<b>2005</b>	<p>A law was passed allowing the selling of over-the-counter (OTC) products in other authorized establishments (i.e. outside pharmacies).</p> <p>The number of hospitals transformed into public enterprises was increased. A new legal statute was adopted to signal that there was no intention of privatization.</p>
<b>2006</b>	Family health units (USFs) were created. The goal is to bring GPs closer to patients. The GP payment system depends on their performance and on the case-mix of their patients.
<b>2007</b>	The values of co-payments were updated. Co-payment was expanded to ambulatory surgery and hospital admission. The prices of pharmaceutical products decreased for the second consecutive year, by administrative ruling. A major restructuring of the Ministry of Health is under way.
<b>2008</b>	The Charter of patients' rights to access health care was published. An administrative ruling lowers the maximum price of generic drugs.
<b>2009</b>	The Ministry of Health approved the National Strategy on Quality in Health Care. Hospitals are allowed to host pharmacies (other than the hospital pharmaceutical department). The co-payment on inpatient

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admissions is abolished.

**2010** The Ministry of Health set the new pediatric age at up to 18 years old. All the hospitals are forced to present a plan to reduce expenses, due to the economic crisis in the country. The shortage of physicians leads to the hiring of retired physicians by the Ministry of Health. The prescription of unit dose pharmaceuticals is approved. The Ministry of Health nominates the Group for the Primary Health Care Reform, together with the new governance model for the reform.

SOURCE: Adapted from From Simões, J.A. - Portugal : Health system review, 2011